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THE  
ILLINOIS MEDICAL JOURNAL

CONTAINING THE

Official Record of the Proceedings of the Illinois State  
Medical Society and the Papers Read

AT THE

MEETING AT QUINCY, MAY 20, 21, 22, 1903

AND THE

Proceedings of the Affiliated Societies, Together With Editorial Dis-  
cussions and Items of Interest to the  
Practitioners of Illinois.

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EDITED FOR THE SOCIETY UNDER THE DIRECTION OF  
THE JUDICIAL COUNCIL BY

GEORGE N. KREIDER, A. M., M. D.

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VOLUME IV.  
JUNE, 1902, TO MAY, 1903.

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SPRINGFIELD:  
ILLINOIS STATE JOURNAL PRESS

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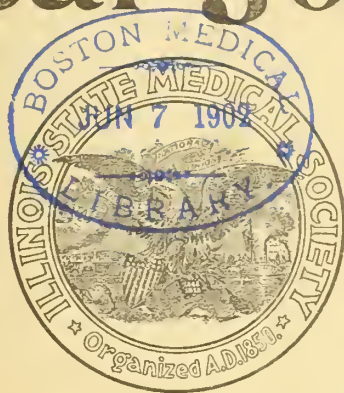
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A. E. S.

# ILLINOIS Medical Journal



The Official Organ  
of the  
State Medical Society

Monthly Under Direction  
of the  
Judicial Council.

Printed by  
THE ILLINOIS STATE JOURNAL COMPANY.  
Entered in the Springfield Postoffice as Second-Class Matter.

Volume LI, {  
New Series, Vol. IV. {  
Number I. {  
Springfield, Ill., June, 1902. {  
Subscription, \$3 a Year.  
Single Copies, 25 Cents.

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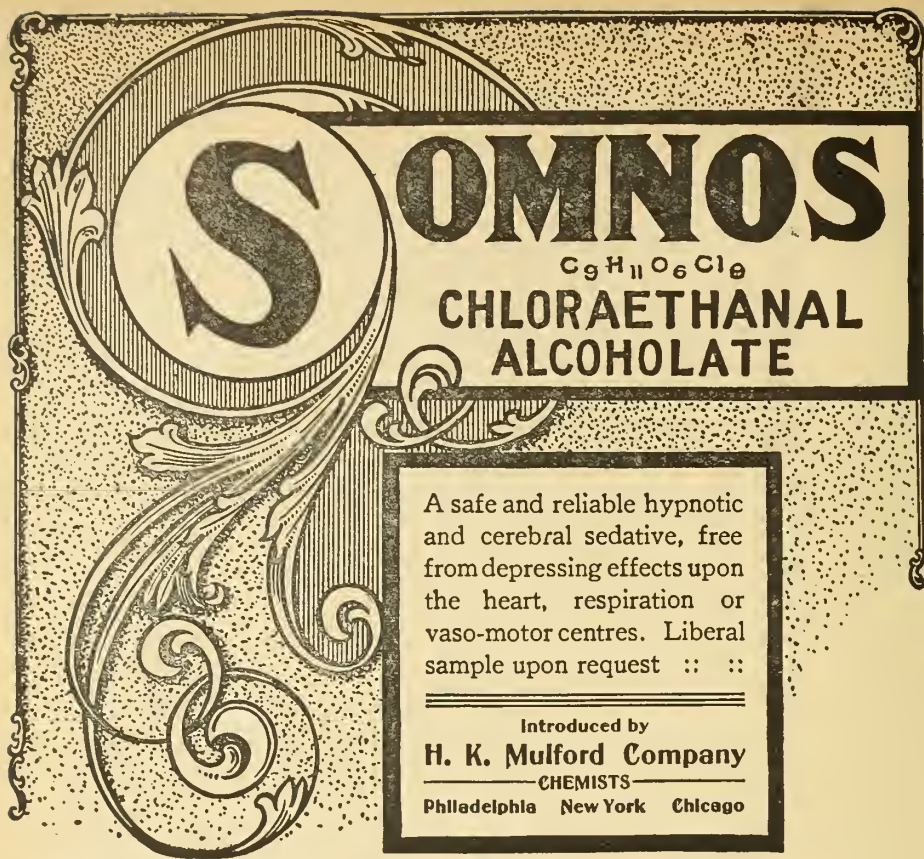
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# The Illinois Medical Journal.

The Official Organ of The Illinois State Medical Society.

4433  
VOL. LII.  
New Series, Vol. IV.  
No. 1.

Springfield, Ill., June, 1902.

{ SUBSCRIPTION  
\$8.00 A YEAR.

## PRESIDENT'S ADDRESS

### SOME OBSERVATIONS CONCERNING OUR COMMON SCHOOLS FROM THE DOCTOR'S STANDPOINT.

JOHN T. M'ANALLY, M. D., CARBONDALE.

The selection of a theme to present upon such an occasion as this is naturally a matter of no little anxiety. Inspired by the presence of a large assembly of the medical fraternity, one is strongly tempted to discuss topics of a purely professional character. But we recognize the fact that the audience gathered here in this magnificent auditorium, is composed of all classes and professions, and it would seem appropriate that whatever subject is discussed, should be of a "Borderland" nature. If I may be able to present a few suggestions as to the medical intervention in such cases, the distinguished speaker who is to follow me on the program will ably discuss the side of "surgical intervention."

I cannot conceive of any subject of more universal interest than the education of our boys and girls in the common schools of this country. I shall attempt at this time, to offer a few suggestions concerning our common schools, from the doctor's standpoint.

The subject of popular education is so intimately associated with the progress of civilization that it can never become trite so long as the human race endures. Every question and every phase of education is, in the mind of the public, an important one.

The ever changing conditions of human life from generation to generation brings new problems for the school. These problems are never solved, but they are so interesting and so profound that they demand the earnest consideration of teacher, parent and doctor.

\* Delivered at the 52nd annual meeting, Quincy, May 20, 1902.

In discussing the question of our common school education, I desire, in the first place, to call your attention to one proposition which I consider well established in the minds of all. This proposition refers to the three fold nature of the work of the school.

The common school has for its ideal, the *mental, moral and physical education* of the children of the nation. It recognizes the fact that man is created a trinity in unity and that his education must take this into account. For many years it was the prevailing belief that the work of the school was purely *intellectual* training; that the home and the church should look after the morals and the child himself, with the aid of the family doctor, should take care of his body. But this view has largely given way to the more wholesome one that the school should seek to train the pupil for his environment, that it should carefully nurture all his powers—*physical, moral and intellectual*.

The common schools of this country, will in the future give more regard to the development of the physical nature of the pupils, than they do at present. It is not an uncommon observation that pupils leave school with less of physical vigor and strength than when they entered. This is especially true of girls, and it is the inevitable result of too close and continuous application to their studies and neglect of proper physical exercises.

That there is good foundation in fact, for the discussion of recent years, of that vital question of intellectual overpressure, in our schools, cannot be doubted.

The fact is, that all living, whether inside the school-room or outside in this busy world, is too intense. It is an age of spend-thrift, intellectual and material. I speak it as a note of warning and let the teacher and physician, who is the conservator of the health of the people, keep it ever before them, *that present day methods in the school*

*and in all the activities of life, are too strenuous.*

That this is true is attested by the ever increasing list of nervous disorders and insanity; by the increasing prevalence of the great American malady, dyspepsia, the closing of brilliant careers among public men whose vital forces early become bankrupt, and the every day fatalities resulting from Bright's disease, heart failure and suicide; they all tell the same story of dissipation of vital energy, nerve tension and of disregard for the laws of hygienic living.

In discussing the question of our Common Schools from the doctor's standpoint, it is not my intention to criticise, primarily, the course of study or methods of instruction, but to offer some suggestions which may aid in understanding more clearly the aim and scope of the work of the common school with reference to the health and physical requirements of the pupils. It would be impossible to discuss this subject, in detail, on this occasion and in the short time allowed for this paper. I must therefore content myself with presenting a few thoughts which seem to me most worthy of your consideration.

#### HYGIENE.

The teaching of hygienic laws and hygienic living, should go hand in hand. We know that precept and practice do not always conform to each other, but they ought to. It is proper that the children should be thoroughly instructed in the principles that underlie the maintenance of good health. But such instruction is of little value unless it becomes effective in the life.

The enforcement of correct physical habits, is a part of the teacher's work. This position is strongly emphasized by that eminent educator, Dr. E. E. White, who says that "The essential duty of the school is to see that the hygienic knowledge taught, takes practical issue in right habits of conduct. It is not enough to teach children the facts relating to cleanliness, posture, exercise, pure air, etc., but they must put these facts into practice, at least while at school."

"Much excellent instruction on the bad effects of breathing impure air is given in the school-room which presents, *at the time,*

a practical illustration of the evil condemned; and it sometimes happens that the teacher is a living example of the consequences of an habitual disregard of the Laws of Health."

"What is needed is a clear recognition of the fact that hygiene is not simply a science, but an art to be practiced. Health is one of the fundamental arts and it should be as faithfully taught in the schools as reading or numbers."

#### ANATOMY.

The teaching of anatomy, in the grades below the high school, is of secondary importance to that of physiology and hygiene. Too much time is often given to dry anatomical details. To remember the description of bones and muscles and their scientific names, is but a freak of memory. Only for older and more advanced students is any considerable amount of anatomical study profitable. For them it will be found not only instructive, but very interesting to study the coarse anatomy and in some cases the minute structure of organs and note the nice adaptation of structure to the varying functions, as for instance, in the intestines where there are millions of small villi projecting like so many little rootlets into the digested food for the purpose of absorption. Only just enough anatomy should be taught to serve as a basis for the more important subjects of physiology and hygiene.

#### TEMPERANCE.

Another subject required by law, and given a prominent place in the course of study, is that of temperance. There has been, in recent years, no little discussion concerning the teaching of scientific temperance. Would it not be better to change the phraseology so as to read the scientific teaching of temperance?

It must be remembered that there is not now, and never has been, a consensus of opinion among medical men or among chemists and physiologists, as to the food value of alcoholic beverages in health or of their remedial value in the treatment of disease. However, the trend of belief among medical men today, seems to be toward a very restricted use of alcohol as a therapeutic agent, although it has been handed down



from generation to generation, as one of the most valuable agents at the doctor's command. But there is one phase of this subject about which there can be no difference of opinion; and it is that phase of the temperance question which should be most dwelt upon in our schools. I allude to the *social and economic* evils of intemperance. The facts regarding intemperance should be clearly and fully taught. Such facts as the insidious growth upon an individual who habitually uses it of an overmastering desire for strong drink; of its degrading influence upon the individual; its curse to the home in blighting love and driving away the angel of peace and happiness; its demoralizing effect upon society by engendering a lawless spirit, increasing to an enormous rate the list of criminals and the army of dependents, filling our jails and penitentiaries, and almshouses at an enormous cost to the State. Such social and economic facts, if properly taught, would make a profound and lasting impression for good upon the minds of the young people of our nation.

#### FOOD.

One of the most practical subjects that could possibly claim a portion of the pupils time, is that relating to food. In a recent paper upon this vital subject, Prof. W. O. Atwater has this to say:

"When we consider that half the struggle for life, is a struggle for food; that half or more than half the earnings of the wage-earner is spent for the nourishment of himself and family; that not only a man's power for work, but also his health is largely affected by his food; that some of our most skilled hygienists are telling us that a large part of the diseases which embitters life and hastens death is due to avoidable errors in diet; that more harm comes to the health of the community from erroneous habits of eating than from the habitual use of alcoholic drinking; that economists, philanthropists and divines are urging more and more earnestly the need of such subjects, are we not justified in asking if a little more room cannot be found for it in the common school curriculum?" It is admitted that the curriculum is crowded. But there can be no justifiable reason for crowding out or even

assigning to secondary place such important subjects as the kinds of food necessary to properly nourish the body, their source of supply, their chemical composition, digestibility and nutritive values, the best means of selecting foods, their preservation, preparation and the common errors of diet.

The growing importance of these topics in the public mind is attested by the fact that domestic science is knocking for admission at the school room door, and in some places the door has opened.

From a health, as well as scientific standpoint, we are of the opinion that educators do not give sufficient attention to the different temperaments of children, with reference to the character and the amount of work required in the school. Here is a boy of sluggish temperament, slow of speech and manner. He requires constant prodding. He must work in school and out and then does not measure up to the average of his class.

On the other hand, here is a girl of the same age, of nervous type, with clear skin, blue eyes and slender build. Her lessons are always perfect, she is the joy and pride of her teacher; but she should not be encouraged to do home study. It should not even be permitted; for her outdoor games, and exercise in the gymnasium must be insisted upon.

I like the idea of the school garden first established in Sweden and now found in connection with the schools of several European countries, and a few in this country. Such schools will promote good health, strong nerves and buoyant spirits; and what the children gain in vigor, will more than counter-balance what they lose from text book teaching.

There is too much tendency to make rigid educational rules, and require every child to conform to them; to put every child through the same process and expect the same result. Such methods are as unscientific as they are unjust.

#### SANITARY SCIENCE.

It is a matter of congratulation that the public generally is taking an increased interest in all matters pertaining to public health, to the restriction and prevention of

disease through the agencies of sanitary science. Our efficient State Board of Health is doing much by means of health leaflets embodying plain, concise information as to the cause, modes of spreading and best means of preventing many of the common diseases.

The public press is also a most important factor in the diffusion of such information and instruction. Consequently there is a growing belief that the battle against contagious and infectious diseases may be successfully fought out in a practical manner in every day life. Intelligent people are coming to understand that very many of the diseases that embitter life and often result in death, are preventable by simple means.

The present widespread epidemic of small-pox in this country is a disgrace to the intelligence of our people.

But let us be optimistic enough to believe the day is not far distant, when ignorance, superstition and selfishness will disappear in such measure that they cannot seriously oppose the working of beneficent and scientific laws. A notable example of what can be accomplished by efficient sanitation, is seen in the practical stamping out of yellow fever in the city of Havana. The work was prosecuted along the lines suggested by recent studies as to the origin and spread of the disease by mosquitoes.

The report of the health authorities shows the maximum deaths in that city from yellow fever in the year 1896, of 1,262 and the average, for the last eleven years of 440 while in the year 1901, there were but 5 deaths.

This is a triumph of preventive medicine most remarkable and gratifying, and illustrating the fact now accepted by all that it is much better to prevent disease than to cure it.

Preventive medicine is the important subject for the present, and for the future physician. Sanitary science which has for its object the study of those conditions which promote health and prolong life and prevent disease, is a matter which belongs to the people. The medical profession has no exclusive claims.

In recognition of the value of a more general diffusion of sanitary information,

the Legislature of the State of Michigan, in the year 1895, enacted a law requiring "That there shall be taught every year, in every public school in Michigan, the principal modes by which each of the dangerous, communicable diseases are spread and the best methods for the restriction and the prevention of every such disease."

It requires further, "That the State Board of Health shall annually, send to the public superintendents and teachers throughout the State, printed data and statements which shall enable them to comply with this act, and school boards are hereby required to direct such superintendants and teachers to give oral and blackboard instructions, using the data and statements supplied by the State Board of Health." In view of the already crowded condition of our curriculum I cannot agree with our Michigan friends as to the propriety of including such instruction as is contemplated in this act in the common school course. The value of such information to the individual, and to the public, cannot be doubted, but it must be borne in mind that the work of education is not limited to the school room. The home, the church, the public press, every function of society and the manifold activities of business contribute immeasurably to the education of a human being. Many examples of educated men can be noted who had but little school training.

While I do not deem it advisable that our school children receive direct instruction in school, in sanitary matters, I do consider it highly important that the teacher be informed on this subject; and this point I would insist upon as necessary to the attainment of the broad purposes of education. The school is what the teacher makes it.

Whatever is done to uplift the common schools of this country must be done through the teachers. It is the teacher that makes effective all the theories and all the appliances of education.

However perfect may be the sanitary condition of the school room and premises, however judicious the plan of study, whatever rules there may be concerning the health of the children, there can be no satis-

factory results except through the intelligent efforts of the teacher.

It is therefore necessary that the teacher should receive special instruction in hygienic and sanitary science as applied to school life. This should be a part of his professional course of study. In some measure this is now taken up in connection with the study of pedagogy. Such subjects are considered as ventilation, lighting and heating of buildings, the distribution of studies with relation to the age of the pupil, the time of day best adapted for different branches, the proper relation of exercise and rest.

But this is not enough; the teacher needs to know something of the germ theory of disease, of the subjects of infection and disinfection. He needs to be familiar with the symptomatology of the common infectious diseases so that when a child appears in school with an eruption, or rash, with sore throat and fever, with sneezing and redness of eyes, with swelling of the face or neck, or with paroxysmal cough, he will be enabled to attach proper significance to every indication of disease and act accordingly.

By promptly recognizing the onset of disease, the inspector may be notified, the child may be sent home and isolated from his fellows and the spread of disease limited, if not entirely prevented. Besides the diseases referred to, there are many accidents which occur in the school room or on the play-ground such as fainting, epilepsy, wounds, sprains, fractures, dislocations and drowning.

Whenever a case occurs, the teacher should know what to do or at least to render intelligent first aid. The point I would insist upon then, is, the special training of teachers in all sanitary subjects, that apply to the school; and that every normal school instituted for the purpose of giving teachers the instruction and training that will best fit them for their high calling should have a chair of sanitary science.

#### MEDICAL INSPECTION WITH VITAL STATISTICS

From the doctor's standpoint, the subjects of medical inspection and vital statistics of the school population are deserving of the most careful consideration. Their value lies

along the line of the prevention and limitation of disease.

The experience of our larger cities, so far as medical inspection is concerned, indicates its value, both from the standpoint of health and economy. The first year of medical inspection in Chicago showed a decrease as compared with the preceeding year of 628 cases of diphtheria and 2,325 cases of Scarlet fever and a decrease of 353 deaths from these two diseases.

Such facts would seem to preclude the necessity for any further argument in favor of the system. The necessity for medical inspection in rural districts, and in small cities or villages is not so apparent, but even there it could be practiced with great advantage, once a term or once every three months. At stated intervals inspectors should take into account other than simply the contagious and infectious diseases. Their inspections should embrace every pupil and form a part of the vital statistical record of every school. Daily medical inspection would be unnecessary in rural districts. It could safely be left to the discretion of a properly trained teacher to call the inspector as needed.

Every school should be supplied with a *register* of sufficient size to contain a record of each pupil during the time he attends school. These records should be carefully kept from year to year and should be more comprehensive than any heretofore devised. There should be entered on record full particulars of each boy and girl embracing items of individual and family history such as name, age, race, sex, height and weight; color of eyes and hair, nationality of parents, occupation of parents. When not living, the age of parents at death and causes of death; measurements of chest and head, defects of vision and hearing, previous diseases, hereditary diseases, general development, deformities and previous education. Such additions should be made to the record from time to time, as will furnish a complete history of the child, both vital and educational covering the time he remains in school. It would be difficult to over-state the benefits that would accrue both to the individual and the state, if such records were accurately



kept. They would enable the teacher to record observations that would be a valuable guide to his successor.

Teachers come and go and often work at disadvantage for lack of just such information. Such records would do much to interest teachers and parents in the study of education from the standpoint of health and would be of much scientific value in studying the relations of mental growth and development with those of brain and body. They would also be of value to young men and women in determining their fitness, both mentally and physically for the various callings in life.

The important subject of vital statistics has been greatly neglected in this state. The Illinois State Medical Society, through its committee on legislation aided by the profession throughout the state secured the enactment by our last general assembly of a vital statistic law. This law went into effect on January 1st, 1902, and required the proper recording of all births and deaths.

Of much greater value to the state would be a law requiring accurate vital statistics of our school population containing such data as might be determined by our leading educators and medical men.

The medical profession should be held responsible for the undeveloped state of vital statistics relating to the school population and for the present neglect of school hygienic and sanitary science.

The public has conceded and the doctor has assumed the right of leadership in all matters pertaining to the health of the people. He should therefore be impressed with the greatness of his mission.

The responsibilities that rest upon him continually demand the highest skill of which he is capable, as well as fidelity in the exercise thereof. The medical schools of the future must meet the demands of society for better hygienic and sanitary instruction.

They should not teach less of Therapeutics but more of hygiene and sanitation. For not one doctor in ten has given these subjects the attention that their importance demands. We should not unduly criticize the schools. They are accomplishing noble

work. If we can assist them to do better work, it is our duty to do so. The problems of education cannot be solved in a day. Their solution requires time as well as united effort. The problems present many difficulties for we are all students from childhood to age, and toil as we may, when the Psalmists three score years and ten have been fulfilled our tasks seem incomplete and we lay them down for others to take up.

The medical profession claims a dignified and exalted place in the estimation of the people. Its philanthropic work and noble history justifies such claims, and we will maintain such honorable standing so long as our work is not prompted by selfishness or bigotry, but by that other motive taught by Him who has been called the "Great Physician," *Service for Humanity*.

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#### THE ADVANTAGES OF EARLY SURGICAL INTERVENTION IN BORDER-LAND CASES.\*

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BY ROSWELL PARK, A. M., M. D.

Professor of Surgery, Medical Department, University of Buffalo.

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It is by no means an easy task for one who confines his researches and his clinical work within as narrow lines as does the writer to prepare a paper for an occasion like this, which shall be of interest to a large number of experienced general practitioners. It has been therefore, with no little hesitation, that I have selected as my topic, "The Advantage of Early Surgical Intervention in So-called Border-Land Cases." This term has crept into such common use of late that no definition need be attempted of the cases which should be placed within this so-called border-land. The physician, as such, has had occasion many a time to complain of the gradual encroachment of the surgeon upon what he has considered his own territory, and internists have seen themselves pushed, as it were, from one part to another, and have been compelled to sit almost idly by and see the gradual invasion of organs one after another which until recently were exempt from the surgeon's manipulations.

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\*Address on Surgery before the Illinois State Medical Society, Quincy, May 20, 1902.

Some feeling has even erept up between the camps of their respective followers and not a few expressions of jealousy have been voiced in journals and in public meetings regarding this unexpected and to the physicians undesirable invasion. But we as conscientious men may well agree to disregard all other considerations save the welfare of the patients themselves, and we may at the same time, to mutual advantage, rehearse some of the reasons for this encroachment and inquire with solicitude regarding them. Another aspect of this same old dispute was voiced but a few months ago when Dr. Fitz, of Boston, read before the New York Academy of Medicine an admirable address on "Some Surgical Tendencies from the Medical Point of View" (Medical News, Dec. 28, 1901, p. 1009), in which he took a position, in which doubtless he is most consistent and most sincere, which well illustrates the honest physician's point of view. In this paper he drew rather unfavorable comparisons between medical and operative treatment of certain cases commonly regarded by physicians as hopeless, and alluded rather pointedly to the fact that death not infrequently results from operations, or that if relief be thereby afforded, it is often disappointingly short, and that sometimes the last state of these patients is worse than their first. He acknowledges that general recognition of this fact has led the surgeon to request the earlier transfer of these cases, not only at a time when the disease is not so far advanced, but even before a diagnosis is made and while the physician is still awaiting developments.

In corroboration of his view he presents a table of ten years work done in the Massachusetts General Hospital, showing that in from 60 to 90 per cent. varying according to the year, of exploratory laparotomies, there had resulted failure to relieve or cure.

His statistics are plain and undeniable and yet it seems to me that such argument is a complete *non sequitur*. As a surgeon I would not hesitate to say that nearly all, if not all of these cases, should have been explored much earlier than was done, and that had the Boston surgeons applied the abundant resources of their art early in these

cases, the figures would have been notably altered. And it is because I believe that Dr. Fitz voices the sentiments of a large number of general practitioners, who take but little interest in general surgery, that it is my avowed purpose to take the other side of this controversy, and present numerous illustrations of not only the advantage but the inestimable importance of early surgical intervention in these cases, as contrasted with the advantages of late attack.

Let us take the general operative surgery of malignant disease in any surgically accessible part of the body. The best surgeons of today believe that cancer is a local disease, at least in the beginning, probably an infection, and that if radically attacked while still a local lesion, it can often be cured, the proportion of cures depending on the early date and thorough character of such operation. Obviously the difficulty is to make an early diagnosis and to secure the consent of patients at a favorably early date; nevertheless, the truth of these statements is so positive that I would not hesitate to lay it down for general guidance, as I teach, that *a well-founded suspicion of cancer justifies an operation for its determination and relief*.

If to any fair-minded man, were submitted the following question, "Which is the best in the long run; to make an occasional unnecessary exploration, or to counsel delay until malignant disease is easily recognizable, and when it is too often too late?" I do not believe there would be any doubt as to the reply.

Let us take Dr. Fitz's own presentation of the questionable utility of gastrectomies, or of Kraske operations for cancer of the rectum, and conceding the questionable propriety of these operations, face the condition squarely. Has not every such case probably passed through the hands of several physicians, and have not these gentlemen lost valuable time in studying it for diagnostic purposes and then dallied and delayed with drugs? Every case that has passed on to a point where such desperate expedients need be resorted to, is of itself a reflection on the judgment of the physicians who have failed to propose early surgical relief. Highly then as I esteem the talent and diagnostic skill

of men like Fitz, I must, nevertheless, take issue with them on their arraignment of us in these hopeless cases, and claim that the onus is on those who wait until they are hopeless before proposing surgical intervention. At the same time I thoroughly agree with him that harmful operations should be avoided, and that we should always abstain from harm doing, and that we should cultivate accuracy in diagnosis and knowledge of pathology, since by these "the surgeon will become a better advisor," though "the number and variety of his operations" will, in my judgment, not be lessened but extended. If my own experience, for instance, is a criterion, I would say that these cases rarely come to me for surgery until they have passed through the hands of several physicians, who are too often tempted to retain them until it is a question of desperate expedients as a last resort. And when, after full explanation and truth telling, the patient voluntarily takes the risk of such measures, these very physicians are too often tempted to shrug their shoulders and say, by imputation at least, "Well, I did not believe that an operation would help him, anyway." Thus the surgeon is made to assume the responsibility for a delay which has been counseled by others.

You see, the tendency has been in time past, to use a very common expression, to "save these cases from the surgeon." Many and many a time I have had a doctor tell me that he has kept a patient out of my hands as long as he could, when in truth, he has been guilty of the greatest indiscretion in not invoking surgery long before. How many lives has this policy cost? The profession has yet to learn that true conservatism means, if I may coin a word, *preservation*, and that this is to be secured only by early attack.

Let us now take certain typical diseases of special organs and systems and rehearse some of the conspicuous illustrations of the truth of these statements. Of diseases ordinarily accredited to the nervous system there is perhaps none more common than *epilepsy*, whether traumatic or focal, which, when assuming Jacksonian type, calls loudly for surgical intervention. These cases at first

go invariably to the general practitioners and from them often to the nerve specialists, the latter being more keenly alive to the possibilities of surgery than the former; but a period varying from months to years is usually wasted, during which conventional internal treatment is carried out and much time is lost, during which the epileptic habit or epileptic dementia are more positively declaring themselves. Only at last, as a rule, when the futility of drug treatment has been established, does the general practitioner begin to consider what may be done by surgery. And so these cases come into the surgeon's hands with the *status epilepticus* well-marked or dementia their most prominent feature, and he is expected to remove not only the local lesion but to clear up the clouded intellect and to break up the bad habit of the nervous system. Not once in five times am I consulted about a case of epilepsy when there is any fair prospect of accomplishing what might have been accomplished had the case been surgically attacked earlier.

*Meningitis.* If the dural cavity were to be treated on those broad general principles which obtain in treatment of infections of the peritoneum, we should see much earlier opening and flushing of the same. We have forgotten the lessons enunciated by the younger Gross during the civil war, who reported a number of cases of trephining and washing out of this cavity, cases of septic meningitis following injury; and Souchon's suggestion of drilling numerous small openings in the skull and using these for irrigation, has not been received with the favor which it deserves.

*Lumbar puncture* is another measure which has not yet come into sufficient favor with the gentlemen who practice internal medicine. By its availability, not only for producing surgical anaesthesia, but for exploration and determination of cerebro-spinal fluid, or recognition of bacteria, and for therapeutic purposes, as well by injection as by tapping, (for example in cases of hydrocephalus), it deserves more frequent resort than it enjoys.

In *tetanus* there is but one really efficient and semi-reliable remedy, and this is the antitoxin; but this, as in the case of diph-



theria must be used early and freely. Its introduction into the frontal portion of the brain or into the sub-dural space requires the distinctly surgical operation of trephining, but it may be used to very great advantage without this formidable procedure. The main thing is to use it early and in sufficient quantity. It is unfair to expect of any of the antitoxins that they can have the same effect late in an infectious disease of which they are capable when used in the beginning. It was my good fortune, for example, not long ago, to treat a case of this kind at home, in connection with Dr. Dorr, who recognized the disease in its incipency and gave the coveted opportunity promptly. In this instance we used 23 vials of antitetanic serum and had the pleasure of seeing our patient completely recover. It was a case of the so-called Fourth of July toy-pistol type. Seeing it so early I did not feel it necessary to trephine.

Much might be said with regard to surgical attack upon the *nerve trunks* where the operations for grafting, resection, elongation, exsection, etc., are called for. Too often the physicians treat these cases by electricity, delaying until there has been degeneration of the nerve ends, as well as of the muscle, and when processes of surgical repair must be much more tedious or even doubtful. Of the various neuralgias, it is especially those involving the facial or sciatic nerves that I particularly speak. It happens so often that these cases are treated by gelsemium, nitroglycerin and other vaunted specifics, as well as by opium and those drugs which not only allay pain but wreck the nervous system, until they have reached a point when elimination is seriously impaired and they are constitutional wrecks. Finally when human nature can bear no more they are put in the surgeon's hands with the expectation that he shall afford prompt and final success, although their condition in every particular is toxæmic and unfavorable. Such a patient may stand elongation of the sciatic nerve but when subjected to removal of the Gasserian ganglion, his tired nature may fail to afford the recuperative powers which he needs.

With regard to the ductless glands, especially the thyroid, I will not detain you with

a summary of the time wasted in iodine applications, iodine injections and treatment of that kind. If an enlarged thyroid can be easily reduced by iodine or thyroid extract, or any other internal measure, there is of course no reason why it should be subjected to surgery, but such measures will prove or disprove their own efficiency within a few weeks and there is no reason why these cases should be allowed to go on until enormous size is reached before putting them in the surgeon's hands, except either the wilfulness of the physician or the cowardice of the patient. Even in exophthalmic goitre, that disease which used to be considered as *par excellence* the one to be treated by the medical specialist, we have learned that when drugs fail, as they often will, there should be early resort either to extirpation of the thyroid itself, or to Jonnesco's operation of excision of the cervical sympathetic, which in many severe cases has given far better results, and vastly more promptly, than have been afforded by any other means.

Were I a specialist in throat and nose diseases I should probably take time here to linger upon the numerous cases of so-called *asthma* which have been treated for months or years by various drugs and narcotics which have promptly disappeared after the removal of certain well-known intra-nasal conditions or lesions of adjoining parts. It will be enough, however, if I simply remind you that when a source of reflex disturbances within the upper respiratory tract can be traced, it should be promptly removed even though this require a somewhat formidable surgical operation.

A very frequent condition of the neck in which delay is too often counseled is that of *tuberculosis of the cervical lymph nodes*, whether moderate or extreme in degree. Here months and years are often wasted in futile administration of cod liver oil or of vaunted anti-specifics, when although the conspicuous lesion is in the lymph nodes, the trouble has really originated in the tonsils, in the naso-pharynx or in the teeth. The first thing to be done with these cases, obviously, is to remove the source and origin of infection. This may be to remove post-nasal adenoids or the tonsils, or to send

the patient to a competent dentist. The source of infection being thus removed, there is then some opportunity for specific drugs to exert their expected or desired effect, or there is then a fair opportunity for the surgeon who may see fit to enucleate the diseased parts, and this he will certainly prefer to do, if possible, before secondary infection shall have produced infiltration of and adhesion to all the surrounding structures. It would appear then that primary treatment of cervical tuberculosis must begin usually in the oro or naso-pharynx.

*Pulmonary abscess and gangrene.* In these conditions what spray or application can reach the abscess cavity in any amount that shall be effective? There is ordinarily but one excuse for failure to operate early upon these cases and that is the sometimes insuperable difficulty of locating the lesion and deciding just where to operate. The same is true of certain cases of extensive bronchiectasis where the cavity is so large and contains such an amount of fetid mucus as to amount practically to an abscess.

*Empyema.* I have a general rule which applies to every collection of pus, for that matter whether circumscribed or diffuse. It is this; that *pus allowed to remain will do more harm than can the surgeon's knife if judiciously used.* This applies to every part of the body and is a very conspicuous truth when we have a chest filled with pus. If these cases were not kept so long under medical treatment, waiting for that absorption which does not occur, we should have far fewer cases in which extensive resection of the chest wall is called for. When the physician has waited until the pleura is half an inch thick before he permits or advises an operation, he has encouraged the formation of an abscess with walls like sole leather, scarcely capable of yielding, and which require a long time to come together by the granulating process.

*Heart.* Some years ago Roberts published a monograph on the surgery of the pericardium which opened the eyes, especially of the American profession, to the opportunities of and indications for the aspiration and drainage of the pericardial cavity. The lessons which he taught fifteen years ago, like

those which have been taught by others before and especially since that time, have been either forgotten or not widely enough inculcated. Men will still persist in letting the heart work itself to death in consequence of the pressure of a distended sac instead of tapping the pericardium early, or even opening it and draining it if pus be present. It needs still to be widely taught and insisted that when the pericardium is distended with serous fluid, it should be aspirated and that when this fluid is pus, a thoracotomy should be done and the pericardium actually opened and drained by gauze or by tubing. This will prove life saving when death might result without it. A lesson of my earliest years in practice when I did a foolish thing, has, nevertheless, not been lost upon me. Before I had left one of the hospitals where I was serving as interne, I plunged an aspirating needle, one night, into the pericardial sac, as I supposed, of a man who was suffering from frightful embarrassment of its action, and gave temporary relief. After a few hours, however, he died, and autopsy showed that I had gone through the fluid in the pericardial sac and that the point of the needle had actually entered and almost completely emptied an abscess in the heart wall, because the cavity was nearly empty and the fluid that I drew off was pus, not serum. Since then I have had much less hesitation in introducing a needle in this region.

Strangely enough, one of the most daring of suggestions in a surgical way has come from Brunton, who has been known so widely as a writer on therapeutics. He has recently (*Lancet*, Feb. 8, 1902), proposed surgical intervention for the relief of *mitral stenosis* by exposing the heart within the pericardial sac, after raising a trap-door in the chest wall, then dividing the stenosed mitral opening by the introduction of a fine knife like that used for cataract. He was led to this proposition by experience in experimental therapeutics, but I imagine it will be some time before a surgeon will be found so bold as to resort to it in men.

*Liver.* Abscess in this organ is too often allowed to remain unopened instead of being attacked early. A suspicion of pus in the

liver warrants its exploration with the aspirating needle. No harm comes of putting such a needle into the liver. On the contrary, although the measure itself may be painful, relief is often afforded to pain and resolution of inflammatory lesions stimulated. I have seen this repeatedly in the case of others and have even had to experience both this pain and this relief myself. In my estimation the liver ought to be explored in this way much oftener than it is.

*Tumors of the liver* are now successfully attacked and success comes in proportion to the promptness of this attack. While writing this paragraph I have heard from a patient upon whom nearly three years ago I operated because she had a tumor projecting downward from the liver. She was a very large, fleshy woman and a minute diagnosis could not be made, although the gall bladder was evidently the seat of the lesion. After reaching it I found that the gall bladder was much enlarged, contained calculi, was cancerous and that the surrounding portion of the liver was also involved in the cancerous infiltration. The entire gall bladder along with this infiltrated portion of the liver was completely excised, oozing checked partly by suture, partly by cautery and partly by pressure of drains, and the woman rapidly and completely recovered. My latest information, coming just at this juncture, is that she is as well and as hearty as ever.

*Biliary passages.* I would like to take much more time than can be spared me here in order to express convictions which I have recently formulated in regard to certain lesions of the gall bladder. To epitomize them, I would remind you that there are several analogies between the gall bladder and the appendix. Both are superfluous organs, both are to some extent at least reservoirs, both frequently contain concretions, both connect by small openings with the intestinal canal, both naturally contain some secretion, both are liable to constriction of outlet and a retention of contained material, and in both instances this material may undergo chemical changes which afford toxic matters that find ready entrance into the general circulation. In other words, both

alike may produce by such disturbances a toxæmia which shall be both lasting and serious. Further analogy is afforded by the clinical manifestations of their disorders, since pain, tenderness, indigestion so-called, or dyspepsia, with prostration, auto-intoxication and constipation, even widespread disturbances in secretion and elimination, are results alike of lesions of the appendix and that of the gall bladder. Removal of the diseased appendix when producing such a train of symptoms is now accepted everywhere as a wise procedure, better carried out early than late. If my words and opinion can be counted for anything in the matter, there is, in probably fully as many cases, just as much reason for removal of the gall bladder as of the appendix, though oftener for chronic lesions than for acute. We certainly do not see gangrenous processes so often in the gall bladder as in the appendix. In a constantly increasing proportion of instances I am now carrying out this principle, and I could quote to you a considerable series of cases, done within the past few months, of complete cholecystectomy on exactly the same principle and after a quite similar technique to those followed in removal of the appendix, and with equally prompt and complete relief. Extirpation then is certainly the best operation for this condition when it can be carried out as it usually can be. It is much better than drainage or cholecystotomy or any other operation that I know of. I have now reached a point in my own beliefs and practice where I can say that not only a suspicion of cholelithiasis justifies an exploration of the gall bladder, but that when patients suffer from dyspeptic symptoms with pain and tenderness in the region of the gall bladder, and especially with any evidence of biliary pigmentation, this region should be explored whether the gall bladder can be felt from the outside or not. This is a radical position, I realize, and yet I make the statement with equal positiveness and reason, based on a series of some scores of cases.

*Pancreas.* The more acute the lesion of the pancreas, the more is immediate surgical intervention indicated. When we recall how disastrous may be an infection, a hemorrhage



or an injury of this viscus, we must feel that in these cases every hour lost in securing surgical help is at fearful risk to the patient. There is but one successful treatment for these acute cases of pancreatitis, and that is afforded by the operative method. It should, moreover, be radical rather than moderate. Of course in the more slow cases there is perhaps more time, but even in these drugs are practically powerless. Moreover, the mixed relations of the biliary passages and the pancreas, which are now attracting wide attention, are, of themselves, anatomical features which conspire to make early exploration most desirable. Chronic pancreatitis is nearly always a factor in cases of chronic biliary obstruction, and advanced surgeons of today believe that chronic jaundice not only always justifies and demands operation, but that when this is done it should include investigation of the duodenum and the head of the pancreas, as well as of the biliary passages proper, and investigation which may lead often to opening the duodenum and exploration of the diverticulum of Vater. When chronic jaundice is accompanied by excessive appetite and thirst, and especially by fatty stools, then complete exploration of the pancreatic region is particularly indicated.

*Spleen.* We have still to abandon the ordinary leucaemic and malarial spleen to the physician and concede that these lesions are far better treated by him than by us. There is, however, a particular disease in which the spleen affords the most conspicuous feature, known sometimes as anaemia splenica, sometimes as splenomegaly, and often as Banti's disease which though not first described by him, is nevertheless quite generally called in Italy and elsewhere by his name. This disease is characterized by three stages, first, one of anaemia which may last from three to ten months, second a stage of splenic enlargement, the so-called splenomegaly, and third, a stage of ascites, the second stage being often transitional and of uncertain length, and the third terminating in from six to twelve months. There is often an accompanying enlargement of the liver, which must justify Banti's view that the disease is essentially a toxæmia of in-

testinal origin. It is marked also by increased alkalinity of the blood and a purpuric tendency to bleeding from all parts of the body, such as is seen in the slower pancreatic affections. In this disease drugs have proved of no avail and so soon as it is recognized, the spleen should be extirpated, the prognosis being good both as far as the operation and the subsequent course of the disease are concerned.

*Kidneys.* It has long been known that certain painful conditions of the kidney are associated with increase of renal tension due to an inelastic capsule, and some years ago it was suggested by Reginald Harrison that splitting the capsule might afford relief from renal tension and this constant pain. This became a recognized procedure. On the same principle it has been carried still farther by Edebohls (Medical Record, Dec. 21, 1901.) In all forms of chronic Bright's disease, it being immaterial whether this be of parenchymatous, interstitial or diffuse type. The theory upon which this measure is based is not only relief of tension, but that by decapsulation of the kidney adhesions are produced between the decorticated surface and the surrounding tissues, so that by means of new vessels, what he calls hyperaemization of the kidney tissue is permitted. This encourages regeneration of epithelium, and thus it comes about that the kidney becomes again quite capable of carrying on its function. Even when destruction of tubules by pressure of exudate has made this seem impossible, there is, nevertheless, a rehabilitation and restitution of kidney function. This gradual restoration begins to occur within ten or fifteen days after operation and goes on indefinitely.

My own experience would lead me in some cases even further than this in the direction not merely of decapsulization but of exploration of the pelvis of the kidney. One case which has led me to this statement is briefly as follows: A young lady, a graduate in medicine, was under my observation for over a year for a condition apparently of intermittent hydronephrosis which gave her at times intense pain, at which times I have felt the right kidney to be nearly as large as my double fist. The

trouble was apparently due to kinking of the ureter, although there was a question of obstruction by calculus. Examinations of urine showed repeatedly such an amount of tube casts and other evidences of renal disorganization from each kidney that I hesitated to operate. At last intense pain and suffering had stimulated her resolution to the point where she absolutely forced matters to operation, although at this time her daily output of urine was not over 10 or 12 ounces. Nitrous oxide gas was the anaesthetic used and exploration of the right kidney showed it to be unusually movable, but apparently not enlarged. Not satisfied with freeing it from its surroundings and extensively loosening its capsule, I brought it to the surface of the wound and opening at the center of its greater curvature, thoroughly explored the pelvis with the finger tip finding nothing except a dilated pelvis. I plugged this opening with gauze, lowered the kidney into its place, suspended it upon two tapes of gauze which were sewed to the skin margins, and closed the external wound with silk worm sutures. The gauze inserted into the kidney structure was allowed to remain for five days, the gauze tapes remained for about ten. From this opening in the kidney, after removal of the gauze, not a drop of urine ever escaped; within twenty-four hours she had doubled her previous production of urine, and within a few days was passing an almost normal amount. The urine also cleared up and now at the expiration of months after the operation, she has scarcely any trace of the original condition. She has not, however, been entirely free from pain, although her relief has been very great. A case like this teaches one the advantage of radical handling of these organs and I have not hesitated to repeat it in other instances and always to my satisfaction.

*Ascites.* Telma, of Utrecht, noting new anastomoses between the portal and systemic veins, while making autopsies on cases of ascites, suggested the propriety of producing adhesions between the peritoneum above with the liver and spleen, and of the peritoneum of the abdominal wall with the omentum. The suggestion was first carried

out by Vandermeule in 1889, although without success. Quite independently Morrison, of Newcastle, had made similar observations, and he proposed deliberate friction of the opposed surfaces above mentioned, along with suture of the omentum to the abdominal wall, with drainage of the pelvis for a few days by a glass drain passed through a separate opening low down. These operative procedures constitute of course a deliberate attempt to short circuit, or rather to shut out of the circulation the obstructed portal veins, permitting the blood to pass directly from the portal terminals into the systemic veins. It is founded on anatomical relations and will succeed often if not resorted to too late. Brewer has recently tabulated some 60 cases of which 38 have recovered, with 6 of them apparently positively cured and the majority very much improved. (*Med. News, Feb. 8, 1902, p. 241. See also Weir, Medical Record, 1899, Feb. 11. Packard and Le Cont, Am. Jour. Med. Sciences, 1901; Tilden-Brown, Report of Presbyterian Hospital for 1890; Ito and Orni, Deutsche Zeitschrift. für Chirurgie, 62, p. 141.*)

Inasmuch as the operation must be regarded as still in its experimental stage, it is to be feared that, as too often occurs, patients will not be subjected to it until the cirrhosis or other disease by which it is made necessary, is far advanced. My own experience with it is confined to two cases where it was done very late and in which there was no conspicuous improvement.

*Stomach.* There are three non-malignant diseases of the stomach which are conspicuously amenable to surgical intervention just so soon as diagnosis can be made. These are ulcer, either simple or perforating, benign obstruction and dilatation. If diagnosis of these conditions cannot be made then there is all the more reason for early exploration. The brilliant achievements of Mayo-Robson have shown how safe and how almost invariably successful these operations are, showing how the work of even one man may lift a class of diseases and an entire organ out of the realm of empiricism into that of safe surgical treatment.

*Gastric cancer.* But it is especially with



regard to cancer of the stomach that I want to detain you a few moments. Every one acknowledges that in order to be of value diagnosis must be early, that is at a time when surgery offers a fair prospect of relief, since there is no real treatment for this condition except operation. To be sure, we realize that gastric cancer may run an exceedingly acute course and kill even within three months, and that for such cases there is as yet no help. On the other hand, its course may be apparently latent, that is, without conspicuous gastric symptoms, even though frequent analyses be made. This is especially true when it follows ulcer. There is, as a rule, a latent period lasting from three to five months of mild, if of any gastric symptoms other than vague dyspepsia or something that passes under that name. At this time, of course, it is not possible to recognize it by any of the known tests. Gradual aggravation of symptoms with progressive emaciation constitute the most suggestive features of these cases in the early months. For their recognition each should have only its proper weight. About half of these cases occur under fifty years of age and it is worth while to remember that the disease is known in children. It has no characteristic subjective symptoms. Nausea, pain, anorexia, thirst, distention, dilatation, eructation and vomiting, all of these may occur in other conditions, although vomiting occurs in about 80 per cent of these cases. It is more rare when the openings are free, while the amount of the vomitus is simply an index as to the extent of the dilatation. Pain, which comes usually early, becomes constant and may be referred in such a way as to be misleading. Haematemesis, at first slight, is a frequent accompaniment, but not so much so as in ulcer, nor is it so copious. The general depression and cachexia of cancer are common to malignant disease in any part of the body, although when the disease affects the stomach nutrition must be interfered with and there is more likely to occur a secondary haematogenous infection.

Study of the gastric functions shows that free HCL is usually but not always absent. Inasmuch as only the central portion of the

mucosa secretes this acid and its absence may often be thus accounted for, because the pyloric end does not furnish it. On the other hand the presence of free hydrochloric acid does not disprove cancer any more than its absence proves it. It is also absent in certain other conditions. The secretion of pepsin follows about the same rule or course. So far as lactic acid is concerned its absence does not mean nearly so much as its presence, which is always suggestive but not indicative. The stomach contents in advanced cases may show tissue fragments having a distinct cancerous structure or containing karyokinetic figures, and these are pathognomonic when recognized, but they are never secured early and at most times only with difficulty. So with regard to the Oppler-Boas bacilli, which when present are of importance, but they too are not an early sign.

When, coupled with signs and symptoms rehearsed above, there is distinct tumor in the epigastric region, it is generally supposed that diagnosis is fairly certain and reliable, and the surgeon rarely gets hold of such a case until this period is reached, although some surgeons have regarded the presence of tumor as contra-indicating operation, meaning thereby that it is then too late.

I have had, however, the fallacy of all these chemical and other tests so repeatedly demonstrated in my own work that I have come to feel that the diagnosis of carcinoma ventriculi is at times both difficult and uncertain. Thus, while preparing this paper, I operated upon a man who had been steadily failing, who referred all his symptoms to his stomach and his discomfort to his epigastrium, who had no free hydrochloric acid, but did have plenty of lactic acid in his stomach contents, and who had a distinct tumor in the conventional region. Opening his abdomen, I was, I confess, not much surprised to find that his stomach was absolutely free from any sign of disease or obstruction, and that all his symptoms were referable to an old cholecystitis with adhesions, which furnished the tumor we felt behind his rectus and all his other signs and symptoms. Complete removal of the gall bladder promptly relieved him of pain and started him on a course toward recovery. This case, by the



way, which I expect to discuss in other aspects at another time, affords ample excuse for repeating the rule which I do not hesitate to lay down, that all cases of pain and tenderness in the region of the gall bladder, accompanied by stomach symptoms and evidences of even occasional biliary obstruction, call loudly for exploration of the region of the biliary passages.

I have rehearsed these features of cancer of the stomach in order to show thereby the impracticability, usually the impossibility of recognizing gastric cancer early, the fallacy of the ordinary tests that apply, and the extreme unwisdom of waiting until tumor or cancer fragments, or Oppler-Boas bacilli are found. Realizing all this, let us adopt this rule; let us say that every case of progressive stomach disturbance shall be operated, i. e., at least explored, when, to the stomach symptoms themselves are added any two of the following symptoms:

1. Rapid emaciation.
2. Achlorhydria.
3. Reduced proteid digestion.
4. Lactic acid.
5. Oppler-Boas bacilli.
6. Suspicion of tumor.

If now, this practice be adopted as a rule of conduct I think I can assure you that the risk of an operation will prove far less than the risk of leaving the case undiagnosed. It needs to be everywhere and strenuously emphasized that stomach cancer is a surgical disease, to be dealt with by radical operation at the earliest possible moment. I am sure that both simple and cancerous disease of the stomach will hereafter come much more often under the knife than has hitherto been the case. See, for instance, what surgery may do for dilatation, where gastroplication affords positive relief; for ulcer, where its exsection affords a radical cure; for benign stricture of the pylorus where plastic operations give most beautiful results; for hour-glass obstruction where anastomosis is of great benefit, and even for gastroptosis where gastrorrhaphy may be of much avail. Of all of these it may be said that while internal treatment may alleviate it can never cure.

*Duodenum.* The lesions here which are

most amenable to surgery are those of perforating and non-perforating ulcer, cancer being in the duodenum extremely rare. For these conditions, if anything is to be done, it must be by surgery alone. In most individuals the duodenum can be so exposed as to permit of opening, exploration and even exsection of localized lesions.

*Small intestine.* Cancer and all other forms of obstruction of the small intestine are equally truly distinctly surgical lesions. Only by operation can anything be accomplished, but this operation must be early if we are to avoid a deep or widespread lymphatic involvement. The slightest positive evidence of continual or increasing obstruction of the bowel should, therefore, be followed by exploratory operation.

*Caecum and appendix.* Early operation in cases of appendicitis has been urged and insisted upon so many times and by so many writers, that at this point I need only mention it to show that it is not forgotten. Perhaps the wisdom of early intervention is not shown more positively in any disease which one can think of than in this. So many other surgeons, however, have done full justice to the disadvantages of delay, nay the fatality of delay, that I shall not take your time here by adding to what has been better said. I would simply like to record myself here as siding with those who feel that in acute diseases, early operation is always wise and expedient, no matter whether or no it may transpire that cases get well without it. Early operation is always advisable and will always be commended by good surgical judgment.

*The lower bowel.* So far as the colon and rectum and concerned, I would say that I never have treated a case of malignant or non-malignant stricture of this tube which had not already passed through the hands of others, being treated for dysentery, or piles, or something of that kind. In my own case I do not have to make a single exception to this statement. Too often they have passed long beyond the period when even those formidable operations, to which Dr. Fitz takes exception, would be of any lasting benefit, and too often I have had to make a simple colostomy feeling that the

golden time for radical surgery had passed under medical auspices, and that the best vital interests of the patient would be conserved by less radical attack.

Incidentally also I would call attention to the wisdom of early surgery in cases of minor importance such as ulcer, fissure, etc., where patients are encouraged under medical advice to fool away months or years of time with ointments or local applications, when a good thorough stretching of the sphincter or eurenting of the ulcer would afford complete and final relief. I have known more than one instance of melancholia and of mania relieved by attention of this kind, these patients being thus redeemed from the grasp of the asylums.

*Obstruction of the bowel.* Again it is the lot of every surgeon to see case after case, when it is too late, when not only time but the strength and vitality of the patient have been sacrificed by internal use of cathartics and purgatives, and even the bowel ruptured by too enthusiastic use of irrigations. I think I may say that I never yet have operated on a case of this kind in which there was not the best of reason for regretting the time thus wasted.

So too of *dysentery*. There are not a few cases of obstinate dysentery, whose lives are made miserable, whose time and money are wasted by futile internal treatment, when a colostomy on the right side for purposes of physiological rest of the colon with a later closure of the artificial anus at the proper time, would give prompt relief.

*Tubercular peritonitis.* Regarding operation in this condition, the surgeons are as yet somewhat divided among themselves. The late Dr. Fenger, a warm personal friend in whose surgical acumen I had unlimited confidence, took an attitude in this controversy with which I never could agree. He questioned the advisability and the wisdom of the ordinary abdominal section as often made for this condition. All this shows how men's experiences differ. Within a year past I have had four cases which so distinctly and beautifully illustrated the benefit of this operation, that I should feel as though it were denying a patient an extremely hopeful procedure were it to be refused under

these circumstances. Although I have washed out all these cases with silver solution, I did not attribute the resulting apparent cures so much to the silver salts as I did to the general procedure which seems to me most wise and promising; promising at least a great deal more than can be offered by internal measures alone.

But I could continue this list of illustrations by the hour, long after you were wearied with them. I shall leave out, therefore, the whole category of genito-urinary disorders and the pelvic lesions of women, among which could be found just as striking examples of the wisdom of early intervention. I even resist the very strong temptation to speak of the various conditions called rheumatism which are not rheumatism at all, including acute osteo-myelitis, bone abscess, tubercular joint diseases, etc., whose distinctly surgical character and therapeutics are too often overlooked by general practitioners. An entire hour might easily be devoted to the so-called rheumatisms which are not rheumatism at all. Fearing even now lest you have been wearied I would conclude these remarks by one or two disclaimers. In all that has been said I have never meant to hold up surgery as a panacea for all ills. The man who voices such sentiments as I have expressed might even be accused of having interested motives, yet the facts remain that if our sole aim is to give final and complete relief in the shortest time, the surgical route often affords it. By availing oneself of surgical measures a patient may often be cured while, according to the older routine, the physician would still be studying to make a diagnosis. Thus, by surgery, may often be done the greatest good to the greatest number in the shortest time. Therefore, I protest again that it is too bad to blame us for lack of success in advanced cases and at the same time keep us from securing these cases early instead of late.

In justice to myself in closing I simply want to disclaim any intention of offending a large class of men capable, competent and sincere general practitioners, upon whom my remarks might otherwise seem to reflect. They are so busy with their legitimate duties

and concern themselves so much with internal therapeutics, in which they are such masters, that the worst I could or would say of them is that their line of research does not include those surgical measures which I so warmly advocate, and it is scarcely to be expected that they should be as well informed in one direction as in the other. But few of these worthy gentlemen are so hide-bound as not to recognize broad general truths and few if any of them are selfish enough to keep patients from securing the best that can be afforded whether it comes through medical or through surgical hands. Conventional and conservative most of them certainly are, and that is why we get our cases so late. That too, is why I have talked to you as I have today. One other thing needs be said; I well realize that often it happens that when physicians advise an operation early, the patient will not consent, the mere thought of surgery being enough to entirely upset the equanimity of a certain portion of human beings. If patients thus deliberately deprive themselves of that which can be done for them, we may regret it but it is not the fault of our profession. It would seem possible, however, by educating the laity and by familiarizing them with the progress of our art, to bring about a gradual revulsion of feeling, so that patients can be brought to consent early to that which is for their real interest.

### A COUNTRY DOCTOR'S CONTRIBUTION TO PREVENTIVE MEDICINE.\*

BY CHARLES B. JOHNSON, M. D., CHAMPAIGN.

The seventeenth day of May, 1749, was the birthday of one destined to exert a tremendous influence for good upon the health and longevity of the human race. The place of birth was the little village of Berkley in Gloucestershire, a dairy county in England.

Here surrounded by green fields and breathing the pure country air, the child grew into a lusty country boy who passed his early days in close contact with nature.

Through wood, dale and meadow he wandered, and beside brook, stream and pond he loitered; while bud, leaf, flower, plant, shrub and tree caught his eye, and bird, animal and insect life, drew and fixed his attention. For

"To him who in the love of nature holds  
Communion with her visible forms, she speaks  
A various language; for his gayer hours  
She has a voice of gladness and a smile,  
And eloquence of beauty, and she glides  
Into his darker musings with a mild  
And healing sympathy, that steals away  
Their sharpness ere he is aware."

The gentle wooings of nature were not lost upon one endowed with the tastes and sentiments of this country boy, and to, in some degree, gratify these no field, to his young mind, seemed to offer better opportunities than did that of medicine. Accordingly at the age of fourteen years he became the apprentice of a Mr. Ludlow, a local surgeon of Sudbury, a small town in the south of Gloucestershire.

For seven years our country boy remained in the office of this country surgeon. Seven common-place years, seven years of hum-drum life, it would seem, as viewed through the mists of some hundred and thirty odd years. A common-place hum-drum life, however, broken into by one incident of especial interest when seen from the view-point of subsequent developments.

One day a country maid came to the office to secure some professional advice, and in the conversation that followed the possibility of contracting smallpox being incidentally referred to, the girl said, "Oh, I'm not afraid of that disease for I've had the cowpox."

All unconsciously this plain, unlettered country girl was in a way enacting again the part of the sower in the parable and her words "Oh, I'm not afraid of that disease, (smallpox) for I've had cowpox," fell upon the ears of the surgeon, as in the parable fell the seed upon stony ground where it withered and perished.

But to the student these words were pregnant with meaning and upon his ears fell, as fell the seed upon good ground where it sprung up and brought forth a hundred fold. But of the seed, of the good ground

\*Address of Section Three, delivered at the 52d annual meeting, Quincy, May 20, 1902.



and of the fruitful springing up, more hereafter.

In 1770, our country boy, just arrived at the years of manhood, went to London, where he became, and for two years remained the student of the celebrated John Hunter. And thus came about the linking together of two great names in English medicine, namely, those of John Hunter and Edward Jenner.

However, in temper, in disposition and in manner, two persons could not well have been more unlike than were these two men. Impatient, petulant, overbearing, quick to anger, and not always choice in language the great Hunter. Good-natured generous, courteous, considerate in speech, the soon-to-be, equally great Jenner. But in an inherent desire to pry into the secrets of nature, and in being gifted with a rare insight into her mysteries, master and pupil had enough in common to early mold and later cement a friendship that lasted during the life-time of these two great English men.

During the two years that Jenner was with Hunter the idea that an attack of cowpox would render a person immune to smallpox was more than once broached by the pupil. But to the mind of the master the suggestion in large degree bore the same relation as in the parable, did the stony ground to the good seed. The same suggestion was made to one and another of London's leading medical men by Jenner, but again and again was it the case of the good seed falling upon barren soil.

His two years of pupilage with John Hunter over, Jenner returned to his little native village of Berkley where he at once took up the practice of his profession. So prevalent was smallpox in this age that early in the eighteenth century, "fighting fire with fire" was, so to speak, the recognized method of preventing some of the ravages of this scourge. In other words an attack of smallpox, moderate in severity, was induced by inoculation. For the benefit of my lay hearers I will say that inoculation, as usually practiced, consisted in introducing under the skin of a person who had never had this disease, matter from a smallpox pustule with

the object of inducing an attack in mild form. Fortunately in the great majority of instances the desired mild attack resulted, but exceptionally the inoculated disease assumed a malignant type and death carried the patient to an untimely grave.

But whether mild or severe, whether induced by inoculation or contracted in the usual way, smallpox is invariably one of the most contagious of diseases. So that while as a result of inoculation a person might pass through the malady with little inconvenience to himself, and in consequence be immune to future attacks, yet while suffering from the disease, he would be liable to infect others and thus possibly start an outbreak that in running its course might claim thousands of victims.

But however fraught with danger, inoculation offered to the individual so many advantages over the risk of contracting the disease in the usual way that its adoption came to be wide spread during the eighteenth century. So that as regards the prophylaxis of smallpox, the eighteenth may be denominated an inoculation century as may the nineteenth a vaccination century.

To secure if possible a better method of preventing the ravages of this pestilence than that of inoculation had come to be a leading object in Jenner's life. And towards the attainment of this great end he directed his attention shortly after beginning the practice of his profession at Berkley.

Some of the common people, especially certain of those who had to do with domestic animals were firm in the faith that such persons as by accident had sores on their hands while working with horses that had the "scratches," or that milked cows with ulcers on their teats, were thereby likely to receive something in their systems that made them immune to smallpox. Indeed, it was the faith of these people that the Sudbury girl embodied in her words, "Oh, I'm not afraid of that disease for I've had the cowpox." Words that as we have seen so profoundly impressed Jenner when a young medical student.

But unfortunately this faith of the common people was based on evidence so confusing and conflicting in character, that save

Jenner, no medical man had been impressed by it. Indeed, the whole subject was as a tangled skein, that seemed to be knotted, twisted and hopelessly tied into little else than a useless snarl.

But running through this confusion of fiber, the keen eye of Jenner detected the golden thread of truth, priceless in value could it but be disentangled. To do this required time, patience, industry, tact, insight and more than all most uncommon of all gifts, common sense.

The horse-barns and dairy farms about Berkley afforded Jenner opportunity for the study of the matter he had in hand. He had become convinced from observation and conversation with the working people that there *were* certain persons who after having sores of a certain character on their hands attended with given constitutional symptoms were immune to smallpox. But unfortunately there were other persons with seemingly the same experiences who when exposed, took this disease.

Jenner now set about a thorough examination of the whole subject at first hand, so to speak. In both man and animals a careful study was made of the nature and symptoms of cowpox. That it was an attack of this disease that conferred immunity, he finally came to regard as little else than a certainty.

Thus the problem that had so long vexed the mind of Jenner seemed near its solution. From the snarled and knotted skein of conjecture and uncertainty the golden thread of fact seemed about to be disentangled.

But to satisfy the rigid demands of science the question must need undergo the unerring trial of experiment. And to the exactions of such a trial Jenner did not hesitate to resort.

Finding a girl by the name of Sarah Helmes with unmistakable cowpox, Jenner on the 14th day of May, 1796, transferred lymph from a vesicle on this patient to the arm of James Phipps, a healthy boy about eight years of age. In a few days the boy passed through a typical attack of cowpox. So far, well and good. But the experiment was only half complete. The crucial test was yet to come.

July 1, 1796, forty-six days after the lymph had been put in the arm of the boy, James Phipps, he was inoculated with the virus of true smallpox and results awaited. The hours ran into days, the days into weeks, but the boy remained well. Later the weeks ran into months and the months into the years of a long lifetime, but to the day of his death, James Phipps continued immune to smallpox, though in all as many as twenty attempts were made to induce this disease in his person by inoculation.

But satisfactory as was this experiment Jenner did not feel justified in making it the basis for a publication to the world of the merits of vaccination and like a true man of science he resolved to seek yet farther evidence.

Unfortunately before another natural case of cowpox came under his observation two years went by. But from this case he again vaccinated a boy, from the arm of this boy a second, from the second a third and so on till the series reached five in number.

Each of these developed a typical case of cowpox and when later inoculated with the virus of smallpox the result was negative. Meanwhile sixteen persons who had been accidentally infected with cowpox were inoculated with smallpox and all proved immune.

Jenner had now reached the age of 49 years and having as we have seen proved the faith that so long had been within him, in the year 1798 felt himself justified in publishing a paper entitled, "An enquiry into the cause and effects of the Variola Vaccinae, known by the name of cowpox." A year later he gave to the world a second paper containing a great amount of additional confirmatory evidence, and in 1800, a third paper appeared from his pen the title of which was, "A continuation of facts and observations relative to the variola vaccinae or cowpox." By this time vaccination had come to attract the attention of the civilized world and thousands were vaccinated and of these many hundreds were inoculated with smallpox virus as a sort of control experiment, but not one took the disease.

Thus vaccination started upon its career with the coming in of the nineteenth cen-

tury; a century that has now run its course so that the results of a hundred years of this prophylactic measure have become history. What are these results?

Before answering this question let us for a moment examine the smallpox records for the eighteenth century; a period that as elsewhere noted immediately preceded vaccination. A few years prior to the coming in of the eighteenth century occurred in England what is known as the revolution when William and Mary of Orange became king and queen in place of James second who meanwhile had been deposed. William of Orange who as king became William III. of England, though one of the greatest monarchs that country has ever known, was personally unpopular mainly by reason of his foreign birth. But his Queen Mary II. a native of England, possessed all the attributes needed to make her a popular idol. Young, beautiful, unselfish, kindly in manner, sweet in temper, queenly in bearing, she at once won the love and esteem of the English people.

Near the beginning of the eighteenth century, London was visited by a terrible epidemic of smallpox that in its course finally reached the Royal Palace where one of the first to be stricken was the popular young Queen. For days the patient languished as worse and worse grew the symptoms till finally the charming and much loved Queen died a victim to that most loathsome of diseases, smallpox. The death of Queen Mary fell with terrible force upon her husband the King who in his agony exclaimed, "But a little time ago and I was the happiest of men, now I am the most miserable man in all England." But the death of his amiable wife was not the first loss from smallpox William had been called upon to sustain. Some years before his father, his mother and an uncle, the Duke of Gloucester, had died from this disease, as had also two cousins the oldest son and youngest daughter of his uncle, James II. of England. Finally by the same terrible malady William had himself been brought very near to death's door.

For in the old days the palace no more than the hovel could bar its doors against the inroads of this scourge. Among those

of royal blood who perished from this disease during the eighteenth century, may be mentioned the names of Joseph I. of Austria, two empresses, six duchesses, an elector of Saxony, an elector of Bavaria, an heir to the throne of France, a Queen of Sweden, an empress of Russia, and finally Louis XV. of France.

During the eighteenth century it is estimated that among the common people there died from smallpox in Europe no less than sixty millions. From this same disease in one year two million persons died in Russia alone. Of a population of thirty thousand in Iceland, eighteen thousand perished during the prevalence of one smallpox epidemic.

In the year 1721, half the population of Boston in America were stricken with this scourge and of these many died.

During the Revolutionary war Abigail Adams, who had the rare distinction of being the wife of one American president and the mother of another, in writing to her husband, John Adams, then a member of the Continental Congress in Philadelphia, said in reference to the little American army operating in Canada, "Of ten times more danger to our soldiers than Britton Canadian or Indian is smallpox that is now working its deadly way through the patriot ranks. Referring to the ravages of this disease in the eighteenth century, Macauley the great historian and brilliant word painter said, "Smallpox was always present, filling the church-yards with corpses, leaving on those whose lives it had spared the hideous traces of its power, turning the babe to a changeling, at which the mother shuddered, and making the eyes and cheeks of the betrothed maiden objects of horror to her lover."

It was estimated that at this period of every ten persons one was doomed to die of smallpox, and of the remaining nine another one would be hopelessly blind, deaf or otherwise permanently, maimed. It was further estimated that of the whole population ninety-five per cent. were destined to suffer at some period in their lives from this malady. This meant that of twenty persons taken promiscuously but one would during the whole of his lifetime escape from the disease.



From this gloomy picture of the eighteenth century let us turn to one much more inviting to look upon, namely, the hundred years covered by the nineteenth century.

The one picture overcast and darkened by the great black shadow of sixty millions dead and full nineteen twentieths of the population sufferers from smallpox.

The other picture made bright and attractive by the light of statistics that reveal the escape of nineteen twentieths of the people from the ravages of this pestilence.

For such are the statistics of the nineteenth century: But one person in twenty liable to an attack of this disease. And the attack when incurred so mild that little inconvenience, in most instances, results.

This reversal of the figures that go to make up the smallpox victims and immunes during the last two centuries, means in the nineteenth century, when proper allowance for natural increase is made, a saving in life of a population in numbers equal to that which today inhabits the United States of America.

So much for the saving of life among the common people by reason of vaccination. What are the figures as regards royalty?

If a single individual member of a royal family in the civilized world, died from smallpox during the nineteenth century, the fact has escaped my best efforts at research and investigation.

In the hundred years preceding vaccination, then, a long list of smallpox victims beginning with the amiable and idolized Mary of England and ending with one whom his subjects delighted to call the, Well-beloved, Louis XV. of France.

In the hundred years covered by vaccination, not one death in the ranks of royalty. What do these facts mean?

They mean the strongest possible testimony to the preventive powers of vaccination. For royalty never fails to secure the best possible medical advice, and the best medical advice is always in favor of thorough vaccination. And as we have seen under thorough vaccination during the nineteenth century, royalty was absolutely immune to smallpox. While on the other hand without vaccination during the eighteenth century,

royalty was a potent factor in swelling the mortality lists of smallpox.

So much for one class in Europe that during the nineteenth century kept its members properly vaccinated and in consequence reaped a rich harvest of protection against a disease that in the old days had been a veritable scourge in its ranks.

In America we have but one class that is properly vaccinated, namely, physicians and their families.

How many of you have known a doctor to be attacked with smallpox? I have been in the profession for a third of a century and in all this time have known but one physician to have this disease, and his was a very mild attack. But even this mild attack might have been avoided had he been properly revaccinated and not depended too confidently upon the protection he had received many years before in infancy.

I said, by implication, that all doctors believe in vaccination, a statement that while substantially true is not absolutely so. For to the rule that physicians believe in and on their own persons put in practice, vaccination, my medical hearers will recall that there have recently been two notorious exceptions. One of these, name not remembered, exposed himself to infection, took smallpox and died. The other, one Dr. Pfeifer, also recklessly exposed himself, contracted this disease and for weeks was dangerously sick.

Most truly did the Wise Man say: Fools hate knowledge and their instruction is folly.

Fortunately among physicians, anti-vaccinationists are very few in number. And while from the very nature of their employment doctors are much more exposed to the contagion of smallpox than the laity it is nevertheless estimated that among a million practitioners of medicine but three die from this disease, while from a like number taken from the people at large no less than seventy-three fall victims to this scourge.

Consequently remarkable as is the showing presented by the nineteenth century of nineteen-twentieths of the people, as a whole immune to smallpox as compared to nineteen-twentieths, doomed in the eighteenth cen-

tury to at some period in their lives, suffer from this disease. Remarkable I say as is this showing, it would have been yet more remarkable had the people all submitted to proper vaccination. This statement does not rest upon mere assertion but is fortified by statistics.

In the German Empire compulsory vaccination has been in force since 1814. Under this enforcement vaccination is first done in early infancy and thereafter is repeated about once in twelve years. This constitutes *proper* vaccination and what are its results? To answer this question let us institute a comparison. A comparison between properly vaccinated Germany and France, a country that permits its people to or not to be, vaccinated as they wish.

In the year 1899 two hundred and eighty-five German towns with a population aggregating sixteen millions had but four deaths from smallpox. In the same year, namely, 1899, in one hundred and sixteen French towns with a population of eight and a half millions, the fatalities from smallpox aggregated six hundred. In other words properly vaccinated Germany as a reward for its wisdom and foresight reaped a harvest of immunity nearly three hundred times greater than did loosely vaccinated France.

Having thus seen something of the benefits of vaccination, let us return for a moment to its discoverer.

A very few years after as a young practitioner, locating in Berkley, and having in view the general good of the profession, Jenner was the main instrument in organizing a local medical society. Strange to say from this organization, the child of his own brain and heart, Jenner was later threatened with expulsion in the event he did not cease tiring out the patience of his fellow-members with a reiteration of his theories regarding the immunizing powers of vaccination. Verily, "A prophet hath honor save in his own country." Later, however, came the day of Jenner's vindication and triumph. The day when he became famed the world over and in consideration of his great services to mankind was made an active or honorary member of scientific

associations in every land. After a time too, the English Parliament voted him in pounds sterling, the equivalent of a large fortune. Meanwhile crowned heads and the highest dignitaries took occasion to do him honor.

But Jenner possessed far too much common sense to allow these manifestations of honor and appreciation to turn him aside from the even tenor of his way.

He closely watched the results of his discovery the world over, and being of a generous and humane disposition, set aside certain days for the vaccination of the poor free of charge. It is said that as many as three hundred persons had been counted at his door waiting for the great master in vaccination to do this operation upon their persons.

All this time Jenner attended to a general practice that was by no means limited in proportions and in addition never lost his interest in nature. Geology, one or more of the scientific phases of agriculture, the habits of certain birds and the peculiarities of certain wild animals furnished subjects upon which he prepared papers for scientific societies.

In addition to his tastes and talents for natural history, Jenner was blessed with personal traits that made him a great social favorite. He was, moreover, a musician of no mean talent, who played skillfully upon the flute, violin and sang with good taste and execution. Furthermore he had no little taste for literature and wrote verse which is still extant and that is said to possess considerable merit.

Besides the extreme satisfaction that must have come to Jenner from a realization of the fact that through his discovery he had come to be one of the great benefactors of his race, he was fortunate in possessing the attributes and in being surrounded by circumstances that tended to make his life an exceptionally happy one. But it is decreed that all things earthly must come to an end and Jenner's life, happy and useful as it was, went out in a fit of apoplexy in 1828, when it had filled the measure of 74 years.

The place of Jenner's death was the place of his birth and likewise the place where for more than fifty years he had practiced his

profession, namely, the little village of Berkeley. Here his surroundings, no less than his daily round of duties made him most truly, a country doctor.

In conclusion and by way of epitome it may be said that during the nineteenth century, by reason of vaccination, full seventy-five million lives were saved. More than twenty-two hundred years were added to the sum of human life; the faculty of vision in all its nicety of adaptation was saved to countless thousands whose eyes, save for Jenner's discovery, would have been sightless; the sense of hearing in all its acuteness remained to vast multitudes whose ears would have been deaf; and the image of the Creator in all its majesty and beauty was preserved to untold millions whose countenances would otherwise have been hideous to look upon.

And all this benignant achievement the direct outcome of a country doctor's contribution to preventive medicine.

#### PROCEEDINGS ILLINOIS STATE MEDICAL SOCIETY.

Minutes of the Fifty-Second Annual Meeting  
Held at Quincy May 20,  
21 and 22, 1902.

#### MAY 20TH, FIRST GENERAL SESSION.

The society convened in the room of the superior court, at 10 a. m., and was called to order by the President, John T. McAnally, of Carbondale.

Prayer was offered by the Rev. S. A. Dana, of Quincy, after which President McAnally introduced the Hon. J. A. Steinbach, Mayor of Quincy, who delivered the following

#### ADDRESS OF WELCOME.

Mr. President, Ladies and Gentlemen.—As the representative of the city, I appear before you to bid you a hearty and sincere welcome. This welcome means that you are to take off your hats and make yourselves at home. It means that you are among friends, who will try and make your stay while here pleasant and agreeable; it means that you have the privilege to go where you please, to see what you please, and to do what you please; it means that if you do not

see what you want, you are to ask for it, and we will try and furnish it to you. Again, I bid you a hearty welcome to the city of Quincy. (Applause.)

#### RESPONSE BY THE PRESIDENT.

Mr. Mayor.—It is my pleasant duty, as well as privilege, on behalf of the Illinois State Medical Society, to thank you for the very kind welcome which has been extended to us on this occasion. That the welcome is cordial, we cannot doubt, and we want you to feel that our appreciation of it is as sincere as the greeting is cordial.

Seventeen years ago our society met in your city. Since that time your city has grown in wealth, population, beauty and influence, and in the same period our society has more than doubled in numbers and influence. We now have a membership of about twelve hundred. We have, therefore, ample grounds for mutual congratulation, because of our growth and prosperity.

We come together at these annual meetings for two purposes—the one for scientific work, and the other for social enjoyment. The program, which I hold in my hand, indicates the character, scope, and importance of the scientific work of this society.

The social features of this meeting have been amply provided for, and I desire at this time to express our thanks to the local committee of arrangements for all they have done for our comfort and convenience. Doctors, as a rule, have but few holidays. It is said, that their work is “in the shadows of human existence.” And I am sure that occasions of this kind, affording opportunity for rest and recreation, are, in the mind of the doctor, important considerations outside of the knowledge and inspiration he may gather from scientific discussions.

We thank you again for your cordial greetings, and trust that our brief sojourn in your beautiful city may be mutually pleasant and profitable. (Applause.)

The next order was the report of the executive committee which was read by the secretary as follows:

#### REPORT OF THE EXECUTIVE COMMITTEE.

Pursuant to a call of the president, the executive committee met in Chicago on the



5th day of October, 1901. The entire committee was present, with the exception of Joseph Robbins, who however, was represented by Grant Irwin, of Quincy.

The committee of arrangements was instructed to provide suitable places for the meeting at Quincy, as per resolution adopted at the last annual meeting.

It was agreed that Section Three be given the first half of the session, and limited to ten papers.

It was agreed that Sections One and Two shall be in session simultaneously, and that these sections shall be limited to thirty-five papers each.

Moved and carried that the president's address, and the address of Section Three be given on Tuesday evening.

Moved and carried that Section Two be instructed to go outside of the state, if it so desires, for the purpose of obtaining the services of an authority to deliver the address of said section.

It was determined that the chairman of the other sections may select the orator of their respective sections.

It was agreed that the annual dinner shall be on Wednesday night, and that the cost of the same shall be one dollar per plate.

The committee of arrangements was instructed to send out a letter of general invitation to the profession of the state about May 1st.

The secretary was instructed to mail a copy of the program to each member of the society.

It has recently transpired that by reason of the authority given that Sections One and Two may go out of the state to procure their orators; Section Two reported that Roswell Park, of Buffalo, N. Y., would be pleased to deliver its address. He made the condition, however, that it should be on the first day of the session. To do him the greatest honor, after consulting with several members of the executive committee, your chairman saw fit to change the order as decided upon, and propose that he be given the time of Section Three, his address to immediately follow that of the president, and the secretary was so instructed and by him so placed in the order of proceedings. This, however,

your chairman wishes to have understood, should not be an absolutely fixed one, and can be changed to suit the convenience of the society.

THE PRESIDENT: What will you do with the report of the executive committee?

D. W. GRAHAM: I move that the report of the executive committee be adopted. Seconded by Dr. Quine, and carried.

THE PRESIDENT: The next order of business is the report of the committee of arrangements, by R. J. Christie, Jr., of Quincy.

#### REPORT OF THE COMMITTEE OF ARRANGEMENTS.

Mr. President and members: Your local committee of arrangements submit an incomplete report at this time, for the reason that the report of the treasurer of the committee has not as yet been made out. I, therefore, ask the privilege of the association to present a more complete report, along with the treasurer's report, at a subsequent session.

The regular and general sessions of the society will be held in this court room. Section Two will hold its session Wednesday afternoon in the supervisor's room.

Ample space has been provided for the exhibitors, and they respectfully solicit your inspection of their exhibits.

Tuesday evening the meeting will be held at the Empire theatre, at 8. p. m., when the address of the president, the address of C. B. Johnson, and the address of Roswell Park, of Buffalo, N. Y., will be delivered. A musical entertainment of a high order will be given by well-known local artists.

Wednesday, at 2 o'clock, the visiting ladies will be entertained by a trolley excursion about the city.

Wednesday evening the annual dinner of the society will be given at Hotel Newcomb. The dinner will be served at 7:30 p. m., sharp. Tickets are on sale to the members of the society, visiting ladies and exhibitors. Price, one dollar.

Other announcements will be made by your local committee of arrangements from time to time.

On motion, the report was accepted.

Under the head of "Miscellaneous Busi-

ness," WILLIAM E. QUINE, of Chicago, said: There are two attending delegations, each of which claims to represent the medical profession of Rock Island county in this state, and both of whom are knocking at the door of this society for recognition. I move that the question of their application for recognition be referred to the committee on medical societies, with instructions to report at the afternoon session. Seconded and carried.

THE PRESIDENT: We will now listen to the report of the committee on registration.

EVERETT J. BROWN: The constitution requires that the committee on registration shall report advanced registrations up to the evening preceding the first day of the meeting. Your committee has adopted the same method as that which has been pursued in the last two or three years, namely, sending out advanced registration notices, which has greatly facilitated the work of your treasurer. I have received 454 advanced payments, making a total of \$1,362.00, the largest advanced registration we have ever had. The advanced registration this year is larger than the total membership of the society three years ago.

The president has agreed to make the society button a receipt for the dues, and we found last year that quite a number of delinquent members took part in the discussions without paying their dues, by some means or other. We shall try to prevent those delinquents from having buttons if we can possibly do so. The total membership of the society up to the last hour or so was over twelve hundred.

On motion of James H. Stowell, the report was received.

C. W. HALL: A short time ago, Mr. President, a very delicate matter was submitted or referred to the committee on medical societies. I am the only member of that committee who is present, and I would like to have the chair appoint members to fill the vacancies on that committee.

THE PRESIDENT: I will name as members on the committee with Chairman Hall, J. W. Pettit, of Ottawa, and Wm. E. Quine, of Chicago.

J. W. PETTIT: Why would not this be the proper time and place to hear the report of

the committee on revision of the constitution and by-laws?

THE PRESIDENT: If there is no objection, this report can be heard at this time.

At the preliminary meeting, held May 19th, at 2 p. m., which was in charge of the committee on medical legislation, the new constitution and by-laws, which was drafted in conformity with the plan of reorganization of the American Medical Association, was thoroughly discussed, amended, and recommended to the society for adoption.

E. Fletcher Ingals, of Chicago, then read the report of the committee on constitution and by-laws, as follows:

(Text will be published in full in next issue.)

At the conclusion of the reading of the report, Harold N. Moyer moved its adoption seconded by Dr. Pettit.

C. S. BACON: This is an extremely important matter, and there is no particular reason why it should not be discussed by the members. Under the plan of reorganization we are striving to do the best we can for the future of the society, and I would like to get the sense of the members on one point, namely, How shall the society be supported, or how shall the fees of the members be paid? This can be decided by vote in a short time.

I would, therefore, move as an amendment that the provision of the by-laws, which provides that every member shall pay dues of \$3.00 be changed, and that all provisions of the constitution and by-laws necessary to bring about such a change shall be so modified that the following may be substituted:

"An assessment of one dollar per capita on the membership of the component societies is hereby made the annual dues of this society. The secretary of each county society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the secretary of this society thirty days in advance of each annual session. Any county society which fails to pay its assessment, or make the reports required, on or before the date above stated, shall be held as suspended, and only those of its members shall be permitted to participate in any of the business or pro-

ceedings of the society who have subscribed for the current proceedings of the state society." Seconded.

HAROLD N. MOYER: I desire to state that I am heartily in favor of the amendment of Dr. Bacon. It is in line with what has been discussed regarding the reorganization of the state. The plan of bringing in all of the members of the local societies, making them members of this body, is one we ought to aim at. But I submit, now is not the best time to consider this amendment. It ought to be considered next year, at which time the house of delegates, which we are seeking to establish, will be in working order. It will be a working representative body, prepared to tackle and discuss this question, and work out some plan by which it can be consummated. At present, in adopting this new constitution and by-laws, we are simply putting ourselves in line with the reorganization of the American Medical Association, and providing for a working body which will take up this problem. It is a difficult problem, and I think that our solution of it now would be inadequate and imperfect, and it can be solved next year perfectly by the house of delegates. Therefore, I move that this amendment be postponed until next year and that it be referred to the house of delegates. Seconded by Dr. Grinstead.

A. W. BAER, of Chicago: I move, Mr. President, that both the motions of Dr. Bacon and Dr. Moyer be laid on the table. Seconded by Dr. Brower.

THE PRESIDENT: This motion to table is in order, but, if passed, will carry with it the report of the committee.

DR. BAER: I will withdraw my motion, Mr. President.

The Seconder (Dr. Brower) consented to this.

GEORGE H. SIMMONS: As a member of the committee on reorganization of the American Medical Association, I heartily endorse what Dr. Moyer has said. The committee appointed by the society has gotten up this new constitution and by-laws, and if an attempt is made to substitute an important part for the constitution or by-laws, as they now stand, I am afraid that we will get things mixed up. There will be plenty

of time to consider and make such changes next year as the society deems necessary. We shall not be going backward a single step by not adopting the amendment offered by Dr. Bacon. Let us adopt the constitution and by-laws as presented, which will be one step forward, and then next year we can take another step forward.

J. W. PETTIT: This suggestion of Dr. Bacon ought not to be treated lightly. It is an ideal condition that he is striving for, one which we must come to, and it is only a question when we will do it. Dr. Bacon has given the matter a great deal of thought, and what he has said is entitled to the consideration of the Society. However, if we should adopt the amendment this year, I believe we should have to rely largely upon the patriotism of the profession of the State for funds in order to carry on our work for the next year. That is an unsafe thing to do. I will be in favor of it next year, but not now.

C. S. BACON: The question I wished to bring out was to get the sense of the meeting today, and this can be done by a vote on my motion, and the Committee could be instructed to make such changes as the Society deems desirable. If the Constitution and By-Laws are to be changed, the changes must be made in accordance with the provisions for amendments to the new Constitution and By-Laws, which will require a three-fourth vote of the House of Delegates. I should think it would be of interest to the Committee and also to the Delegates to know what the sentiments of the members are in regard to the matter this year. This question was not brought up at the preliminary meeting, I understand. I would like to have the sense of the Society on this matter, which is of vital importance.

THE PRESIDENT put the motion of Dr. Moyer, and it was carried.

THE PRESIDENT: The question now reverts to the adoption of the report of the Committee on New Constitution and By-Laws.

M. L. HARRIS: I rise to a point of order.

THE PRESIDENT: Please state your point of order.

Continued next month.



# The Illinois Medical Journal.

The Official Organ of the State Medical Society.

EDITOR—George N. Kreider, A. M., M. D., Springfield.

Official Reporters of Affiliated Societies—

## COUNTY SOCIETIES.

Adams County—Henry Hart, M. D., Quincy.  
Alexander County—J. T. Walsh, M. D., Cairo.  
Bureau County—H. E. Owens, M. D., Princeton.  
Bond County—W. T. Easley, Greenville.  
Carroll County—H. S. Metcalf, M. D., Mt. Carroll.  
Champaign County—A. S. Wall, M. D., Champaign.  
Calhoun County—T. O. Hardesty, M. D., Kampsville.  
Clay County—Warren Eugene Burgett, M. D., Louisville.  
Crawford County—L. J. Weir, M. D., West York.  
Douglas County—W. E. Rice, M. D., Tuscola.  
De Witt County—J. H. Tyler, M. D., Clinton.  
Edwards County—J. H. Lacey, M. D., Albion.  
Franklin County—W. H. Smith, M. D., Benton.  
Fulton County—D. S. Ray, M. D., Cuba.  
Gallatin County—Geo. P. Cassidy, M. D., Shawneetown.  
Grundy County—H. M. Ferguson, M. D., Morris.  
Hancock County—R. L. Casburn, M. D., Carthage.  
Jersey County—A. K. VanHorne, M. D., Jerseyville.  
Jo Daviess County—D. G. Smith, M. D., Elizabeth.  
Johnson County—J. E. McCall, M. D., Vienna.  
Kankakee County—Henry H. Rogers, M. D., Kankakee.  
Kendall County—R. A. McClelland, M. D., Yorkville.  
La Salle County—W. A. Pike, M. D., Ottawa.  
Lake County—A. G. Haven, M. D., Lake Forest.  
Livingston County—Jno. Ross, M. D., Pontiac.  
McDonough County—R. E. Lewis, M. D., Macomb.  
Macoupin Co.—J. Palmer Matthews, M. D., Carlinville.  
McLean County—E. S. Reedy, M. D., Bloomington.

## DISTRICT SOCIETIES.

Aesculapian—H. McKennan, M. D., Paris.  
Brainerd District—J. L. Lowrie, M. D., Lincoln.  
Central Illinois—F. J. Eberspach, M. D., Pana.  
Galva District—C. W. Hall, M. D., Kewanee.  
Fox River Valley—H. J. Gahagan, M. D., Elgin.  
Military Tract—C. B. Horrell, M. D., Galesburg.  
North Central—Geo. A. Dicus, M. D., Streator.  
Southern Illinois—O. B. Ormsby, M. D., Murphysboro.  
Tri-County—Leroy Jones, M. D., Hoopeston.  
Western Illinois—H. W. Chapin, M. D., Whitehall.

## URBAN SOCIETIES, EX CHICAGO.

Alton Medical Society—Geo. E. Wilkinson, M. D., Alton.  
Decatur Medical—C. Martin Wood, M. D.  
East St. Louis—C. W. Lillie, M. D.  
Jacksonville Physician's Club—D. W. Reid, M. D.  
Peoria Medical—E. M. Eckard, M. D.

Marshall County—W. G. DuFour, M. D., Henry.  
Massac County—C. E. Trovillion, M. D., Metropolis.  
Mercer County—A. N. Mackey, M. D., Aledo.  
Montgomery County—J. M. Trigg, M. D., Farmersville.  
Morgan County—T. A. Wakely, M. D., Jacksonville.  
Knox County—G. S. Brown, M. D., Galesburg.  
Ogle County—H. A. Mix, M. D., Oregon.  
Perry County—J. W. Smith, M. D., Pinckneyville.  
Pike County—R. H. Main, M. D., Barry.  
Pope County—W. S. Dixon, M. D., Rosebud.  
Piaski County—Chas. J. Boswell, M. D., Beechwood.  
Rock Island Co. Ass'n—Jos. DeSilva, M. D., Rock Island.  
Saline County—J. R. Baker, M. D., Harrisburg.  
Sangamon County—F. B. Fisher, M. D., Springfield.  
Schuyler County—A. W. Tull, M. D., Rushville.  
Shelby County—A. G. Mizell, M. D., Shelbyville.  
Stark County—M. T. Ward, M. D., Toulon.  
Stephenson County—R. J. Burns, M. D., Freeport.  
St. Clair County—B. Portuondo, M. D., Belleville.  
Tazewell County—C. G. Muehlman, M. D., Pekin.  
Union County—T. Lee Agnew, M. D., Anna.  
Vermilion County—E. E. Clark, M. D., Danville.  
Wabash County—J. B. Maxwell, M. D., Mt. Carmel.  
Warren County—Adella R. Nichol, M. D., Monmouth.  
White County—W. A. Steele, M. D., Carmi.  
Will County—Herbert S. Worthley, M. D., Joliet.  
Williamson County—G. W. Evans, M. D., Marion.  
Winnebago County—S. R. Catlin, M. D., Rockford.

## CHICAGO SOCIETIES.

Academy of Medicine—J. G. Kiernan, M. D.  
Electro-Medical—Richard H. Street, M. D.  
German—Karl Dopfner, M. D.  
Gynaecological—C. S. Bacon, M. D.  
Medical Society—F. X. Walls, M. D.  
Medico Legal—N. S. Davis, Jr. M. D.  
Neurological—C. H. Lodor, M. D.  
Ophthalmic and Otolological—Brown Pusey, M. D.  
Orthopedic—Edwin W. Ryerson, M. D.  
Pathological—Geo. H. Weaver, M. D.  
Physician's Club—L. H. Mettler, M. D.  
Rhinological and Laryngological—J. E. Rhodes, M. D.  
Rush College—J. B. Herrick, M. D.  
Society of Internal Medicine—Robt. B. Preble, M. D.  
Southwestern—Thos. J. McGonagle, M. D.  
Surgical—D. N. Eisendrath, M. D.  
West—Gustavus M. Blech, M. D.

All communications should be addressed to the Editor, 522 Capitol Ave., Springfield, Illinois.

The Society does not assume responsibility for any statements or opinions published in the JOURNAL.

The JOURNAL is published monthly. The subscription price is \$3.00 per annum in advance. The JOURNAL is furnished free to the members of the Society.

Entered at the postoffice in Springfield as second class matter.

JUNE 1902.

## THE QUINCY MEETING.

### ENLARGED MEMBERSHIP MEANS INCREASED RESPONSIBILITIES.

For nearly fifty years the Illinois State Medical Society pursued the even tenor of its way in a manner common to State Medical Societies the country over. The membership represented about five per cent. of the practitioners of the State and when two hundred of them got together at an annual meeting it was held to show a remarkable interest on the part of the profession. At these sessions lasting about two days, papers

obtained after much solicitation were read, the officers were elected and all save the permanent secretary lapsed, as far as Society activity was concerned, into a state of hibernation. The permanent secretary by dint of much arduous labor in prodding up the readers of papers managed to get out the bound volume of transactions about six months after the meeting. The members by this time had probably lost interest in the subjects discussed and filed the volumes away in stately array on the library shelf. The Society was but an incident in professional

life. However this plan of procedure had its compensations which should not be forgotten now that a change is in progress. The Society was a club of gentlemen. Politics and political methods were but little known at the meetings. Men were called to the offices. Self-seeking politicians had no place. The membership and attendance were so small that each person had opportunity for intimate acquaintance with his fellows. About the close of the last century when everything viable in America began to show symptoms of expansion this Society became inoculated with the prevailing disease and resolved to become a real factor in the professional, political and commercial life of the State. The Journal was established and the membership expanded by leaps and bounds. Too many papers were offered for the annual convocation requiring the division of the scientific program into two sections. The crisis was reached at Quincy last week when the entire membership of ninety local societies became members of the greater Illinois State Medical Society.

Only those who have been in close touch with the work of the Society during the last decade can appreciate the full significance of this event. To harmonize the conflicting interests of nearly 4,000 practitioners scattered over the State, some in hamlets of a few hundred inhabitants and a large proportion in a metropolis of two millions, is no small task. To shut out political wire pullers and keep down political fence building among these thousands will require no little ingenuity. To let the office always seek the man and frown down the office seekers demands self-restraint on the part of the ambitious. We sincerely hope that no abuses will creep in to mar that harmony which has always been our greatest strength. We plead that conservatism may not be cast aside and that haste may be made slowly, always trying all things well and holding fast to that which is good. Let us then not cut loose from our old moorings too hastily but let us on larger foundations, just as strong as of old, build our new structure safely, carefully and happily. If this be done the new Society will not only be the largest, but the most harmonious and in-

fluent State Medical organization in the union.

\* \* \* \*

The Judicial Council received well deserved commendation for its political labors at the Quincy meeting. This was very gratifying to the council and very creditable to the Society. Gratifying to the council because it has had some difficult political problems before it which have been met with firmness and good judgment. Some very wiley schemers who have in the past insulted scientific medicine have been made to feel the power and influence of the organized profession. Of course the increase in our membership will lend added strength to the actions of the council. We believe our four thousand members can influence not less than twenty thousand votes. Political aspirants will hesitate a long time before they run counter to the wishes of this body of intellectual citizens. May the council be as wise and firm in the future as in the past.

\* \* \* \*

The business of the Society was unfortunately in a somewhat chaotic condition at the Quincy meeting. This was probably to be expected because of the change in the constitution, a change which could not be made complete all at once. This confusion probably accounts for the unfortunate fact that not less than seven out of the sixteen delegates and alternates chosen to represent the Society in the house of delegates of the American Medical Association have been found to be ineligible to that honor. One of them, Ex-President Moyer is already a delegate, having been elected from the section of Nervous and Mental Diseases. One appears to be ineligible because he is already an officer, being secretary of one of the sections, another is also an officer being a member of the Judicial Council. Four of the gentlemen named by our Society have not been members of the A. M. A. the two years required to make them eligible to this position. This error on the part of the nominating committee is embarrassing and we reluctantly mention it now that mistakes may be avoided in the future. The president will doubtless appoint substitutes and the Society will be none the loser.

This brings up the matter of the number of delegates from our Society and we can not see why Illinois should not have a full representation for the 3,650 members in her State Society. Our new constitution clearly states that the "Resident members shall consist of all the members of all county or district societies or associations that are organized in harmony with the spirit and object of and which shall (thereby) become branches of the Illinois State Medical Society." We know of one State Society which has elected a full quota of delegates for a large membership on a very liberal rendering of constitutional language. Language which is to be changed at its approaching annual meeting. Ours is clear and definite and should be respected. We have the names of nearly 4,000 members in the hands of the Legislative Committee.

\* \* \* \*

Finally we must speak a word for the officers of our new Society. Dr. Pettit has frequently voiced the proper sentiment of the faithful members by saying that we should stand by the committees which of course includes the officers. It is obviously wrong to appoint intelligent and faithful men for committee work; ask them to devote their time and talents to the allotted task and then have their labors of a year torn to pieces by members who have not given an hour's consideration to the whole business. It is discouraging to the committee. It will be fatal to the morale and esprit de corps of the Society if the committees are not commended and encouraged. While this is true of all the officers it is especially true of the legislative committee which has entered upon the herculean task of securing a new law regulating the practice of medicine. If all our members will but stand as one man, back of the committee their task will be comparatively light, but if there is any considerable dropping out of the ranks or firing in the rear their work will be arduous and perhaps impossible. Let our motto continue to be The profession for the individual practitioner, And the individual practitioner for the profession.

#### NEW INCORPORATIONS.

The Secretary of State at Springfield has granted papers of incorporation to the following companies:

Open Door Asthma Cure company, Chicago; to manufacture proprietary articles; capital, \$10,000; incorporators, Julia A. Dolzall, John Dolzall, and Charles E. Girard.

National Sanitarium company, Chicago; capital, \$2,500; operation of sanitariums; incorporators, S. E. Gorham, William P. Burdett, and E. Johnson.

The Dr. Sweany company, located at Chicago, certifies to an increase in the number of directors from three to five.

Bauer & Black, Chicago, increase of capital stock from \$125,000 to \$200,000.

The Skiles Sanitarium, located at Chicago, certifies to a change to the Garfield Park Sanitarium.

R. Friedlander & Co., Chicago; to manufacture scientific, electrical and chemical apparatus; capital stock, \$50,000; incorporators, Stella E. Gillen, John M. Pollock, and Henry Seligman.

Agard Deaconess Sanitarium of Lake Bluff; for benevolent and religious purposes; incorporators, M. B'anche Ball, Lucy Rider, Meyer, and Lillian Coleman.

Dr. Gossom Medicine company, Chicago; to manufacture drugs and chemicals; capital stock, \$20,000; incorporators, Charles J. Grady, Ernest H. Stolz, and W. H. Keefer.

Dr. Bozinchs Curative Bitter Wine company, Chicago; to manufacture proprietary remedies; capital stock, \$2,500; incorporators, Joseph C. Marson, Julius Rubenstein, and Joseph Staab.

Alfaalfa Remedy company of Chicago; to manufacture medicinal remedies; capital stock, \$50,000; incorporators, J. S. Robertson, D. Dudenhaver, and H. F. Robinson.

Interstate School of Osteopathy of Chicago; for educational purposes; capital stock, \$2,500; incorporators, R. D. Hall, E. M. Murphy, and A. B. Newcomb.

#### Local Societies.

The Bond County Medical Society is composed of the following officers and members: E. P. Poindexter, president, Greenville; J. A. Warren, vice-president, Greenville; W. T. Easley, secretary, Greenville; W. C. Barnes, treasurer, Mulberry Grove. E. A. Glasgow, Mulberry Grove; B. F. Coop, Greenville; C. C. Gordon, Greenville; Ed Gordon, Old Ripley; J. H. Gordon, Pocahontas; D. R. Wilkins, Pocahontas; H. C. Early, Reno; James A. Black, Pleasant Mound; H. E. Wilkins, Sorento; W. W. Duncan, Sorento; J. D. Chittum, Sorento; J. B. Cary, Donnellson; A. B. Cary, Donnellson; H. Schmidt, Beaver Creek; J. W. Hoagland, Smithboro.

The Stark County Medical Society was organized by a number of the physicians of Stark county who met in Wyoming, April 8, 1902. A. M. Pierce, of Wyoming, was elected president, and M. T. Ward, of Toulon, secretary-



treasurer. The society meets semi-annually in Wyoming on the second Tuesday of April and October.

M. T. Ward,  
Official Reporter.

The Jacksonville Medical Club met Saturday, May 3. After reports of various cases Geo. Edwin Baxter read a carefully prepared report of an **Unusually Complicated Case of Typhoid Fever**, together with the bacteriological and pathological findings in the case.

D. W. Reid,  
Official Reporter.

The Tazewell County Medical Society was organized at Tremont, April 29, 1902, with the following members: W. H. Conibear, Morris, president; E. H. Weimer, Pekin; J. W. Cody, Tremont; F. W. Beilstein, Morton; Robt. H. Keyes, Hopedale; H. L. Yoder, Morton; C. G. Muehlman, Pekin, secretary; Wm. Niergarth, Pekin; J. I. Skelly, Pekin.

The next meeting was held at Pekin, May 13th.

The Edwards County Medical Society was organized on April 8, 1902, with the following officers: W. E. Buxton, Samsville, president; J. S. Williams, Albion, vice-president; J. H. Lacey, secretary. H. C. Moss, Albion; Sam'l R. Harwood, Elley, and J. L. McCormack, Bone-Gap, board of censors.

The following are the members: W. E. Buxton, A. C. Low, Albion; A. H. Neimiller, Browns; J. S. Williams, H. C. Moss, J. L. McCormack, S. R. Harwood and J. H. Lacey.

J. H. Lacey,  
Official Reporter.

The Brainard District Medical Society held its 25th annual and silver jubilee meeting in the parlors of the Commercial Hotel, Mason City, Thursday, April 24th, the vice-president in the chair. The attendance was unusually large. The minutes of January meeting were read and approved. Following the annual reports of secretary and treasurer and chairmen of the several committees, the following officers were elected for the ensuing society year: President, W. P. Walker, Mason City; vice-president, W. V. Guttery, Middletown; secretary James L. Lowrie, Lincoln, and treasurer, Charles C. Reed, Lincoln.

Program, Past and Present, by J. W. Newcomer, Petersburg; Surgery, Then and Now, by Henry B. Brown, Lincoln; What Next, by S. L. Hurst, Greenview; Brainard District Medical Society, by L. L. Leeds, Lincoln.

James L. Lowrie,  
Official Reporter.

The Morgan County Medical Society met at its rooms in the Hockenull building on Thursday, March 13, 1902.

The meeting was called to order by P. C. Thompson, the president, the time having been occupied for a half hour or more in examining the X-ray machine of R. V. Wagner in C. P. Powell's office, where power was obtained to run the static machine.

Members present—Hand, of Whitehall; Miller, of Woodson; and Adams, Baker, George Edwin Baxter, Black, Bowe, Burkholder, Campbell, Cole, Dinsmore, Milligan, McLaughlin, Norbury, Pitner, Reid, Thompson and Wakely, of Jacksonville.

R. W. Wagner, of Chicago, was present in charge of the X-ray machine.

Rev. C. M. Brown, Drs. Goodrick and McEnery and Mr. M. D. Rapp were present as visitors.

George Edwin Baxter read a paper on "Methods of Diagnosis From a Medical Standpoint, with Special Reference to the Clinical Laboratory."

E. F. Baker made some extended remarks on "Diagnosis."

C. E. Black read a paper on "Suppuration."

A. L. Adams read a paper on "X-rays in Medicine and Surgery."

F. P. Norbury, Thompson and Adams briefly discussed the papers.

R. V. Wagner, of Chicago, talked on X-rays and spoke of the use of sub-nitrate of bismuth in the stomach so that that organ could be seen more plainly outlined by means of the X-rays; also the desirability of injecting the same medicament into fistulae and the bowels for the same purpose. He also spoke of the therapeutic uses of the X-rays.

On motion the society adjourned and a further exhibition of the static machine was given, which was of great interest to all who were fortunate enough to be present.

T. A. Wakely,  
Official Reporter.

The Morgan County Medical Society met in regular session in its rooms in the Hockenull building on Thursday, April 10, 1902.

George Edwin Baxter was elected chairman pro tem, and presided during the meeting.

The minutes of the March meeting were read and approved.

The chairman announced the program for the May meeting as follows: Artificial Aids in Second Stage of Labor: Instrumental and Anaesthetics, Josephine Milligan, Virginie Dinsmore and T. A. Wakely. Leaders, Reid and G. W. Miller.

Members present—Main, of Barry; Maness, of Nortonville; Wolfe, of Arcadia; and Adams, George Edwin Baxter, V. Dinsmore, Hairgrove and Wakely, of Jacksonville, with G. F. Dinsmore and C. B. Powell as visitors.

R. H. Main, of Barry, read a paper on **Infection**, with some remarks on the contagiousness of pneumonia.

A paper on **Medical Infection**, by George Edwin Baxter, was read by the secretary.

The papers were discussed by Drs. Adams, George Edwin Baxter, Maness and Wakely. Dr. Main closed the discussion and reported some interesting cases of catarrhal jaundice.

The subject of **Surgical Infection** was taken up by Dr. Hairgrove, who mentioned that infection commences with a lesion of the skin or mucous membrane along the bowel tract; abrasions caused by a constipated condition may be the starting point, the bacillus coli caus-

ing infection, with resulting abscess and fistulae. Infection may commence by contact of the skin surface with infective agencies producing septic infection. There is probably no way of combating septic infection except by constant care and precautionary measures. Gloves can be sterilized by boiling; hands cannot be boiled. Bichloride of mercury was mentioned as an efficient antiseptic.

Dr. Hairgrove reported a case of injury following a blow on the abdomen, which caused a traumatism of the liver, probably echinococcus infection. Eight pints of yellow fluid were removed. There was no microscopic examination.

Dr. Adams reported some cases where a misleading symptom of a foreign body in the eye was a factor—the patients asserting that there was something in the eye, when a careful examination revealed nothing present, and feeling was induced by some serious trouble, as glaucoma or irido-cyclitis in their incipient stages.

On motion the society adjourned.

T. A. Wakely,  
Official Reporter.

The Vermilion County Medical Society met the evening of the 12th in the city hall, called to order by Jos. Fairhall as president pro tem.

The board of censors reported favorably on the name of J. G. Fisher followed by his election to membership.

The name of W. O. Lattman was proposed and handed to the censors for their investigation.

The paper of the evening was to have been on **Diseases of the Heart**, but the essayist not being present, the society took up the discussion of the subject which proved very profitable.

There being no further business the society adjourned to the June meeting.

E. E. Clark,  
Official Reporter.

The Decatur Medical Society met in the rooms of the Decatur Club, Thursday evening, April 24th. The minutes of the previous meeting were read and approved.

E. A. Morgan read a paper on **Tubercular Peritonitis**. The paper was discussed by W. C. Bowers, M. P. Parrish, M. D. Pollock, J. N. Randall, Cass Chenoweth, and others.

N. P. Collins reported the case of a young girl, who had, after a slight fall on the spine, repeated convulsive seizures, which resisted enormous doses of morphine hypodermically and chloral per rectum. Recovery was complete in five days. Those members who expressed themselves, gave it as their opinion that the case was one of hysteria.

W. C. Bowers read a paper on **The General Practitioner and His Surgery**. The writer told what the general practitioner could do, and what he could not do, in a surgical way, in his environment. He illustrated his subject by describing a series of surgical cases occurring in his practice.

On motion the May meeting was postponed one week so as not to conflict with the meeting of the State Society. Adjourned.

C. Martin Wood,  
Official Reporter.

The Montgomery County Medical Society met in semi-annual session in the parlors of the Litchfield Hotel, Litchfield, May 6, 1902, with the president, Wm. H. Cook, in the chair. Those answering to roll call were as follows: M. W. Snell, J. F. Blackwelder, T. C. Blackwelder, I. W. Fink, Wm. H. Cook, J. M. Trigg, O. Houser, Baxter Haynes, and T. J. Whitten. Minutes of previous meeting read and approved.

Application of G. B. Trueblood, of Hurricane, was read, and after taking the usual course he was elected.

F. C. Blackwelder, read a paper on **Epidemics**, after which a general discussion followed.

M. W. Snell made a talk on the use of the **Vaginal Douche** either before or after confinement in a private practice in the ordinary homes. He was decidedly against the use of the douche only in such cases as he was suspicious of some specific disease, while some of the other members advocated the douche.

Moved by J. M. Trigg and seconded by Dr. O. Houser that M. W. Snell, of Litchfield, and C. H. Lockhart, of Witt, be elected as delegates to represent the Montgomery County Medical Society in the State Society. Motion carried.

This society continues to grow in membership and I think that it will be among the strongest county societies in the near future.

J. M. Trigg,  
Official Reporter.

The Johnson County Medical Society was organized by a number of the physicians of the county who met in Vienna, Thursday, April 24, and organized. The meeting was called to order by J. T. McAnally, president of the Illinois State Medical Society, who in a brief address explained the benefits and advantages of medical societies generally and locally. A permanent organization was affected, in which the following officers were elected: J. M. C. Damron, Vienna, president; N. J. Benson, Vienna, vice-president; T. E. McCall, Vienna, secretary and treasurer. The following physicians enrolled their names as members of the society:

W. R. Mangum, Buncombe; W. J. Fern, Tunnel Hill; R. A. Cavitt, Tunnel Hill; O. P. Martin, Belknap; H. T. Drake, Belknap; H. O. Williams, Belknap; H. D. LaRue, New Burnside; Jno. L. Whitnel, Ozark; R. M. Fulkerson, Ozark; R. A. Hale, Bloomfield; Thos. Morgan, Goreville; W. A. Looney, R. M. McCall, A. I. Brown, T. E. McCall, J. M. C. Damron and N. J. Benson, all of Vienna; and T. J. Hurst and H. N. Whitaker.

T. E. McCall,  
Official Reporter.

The Grundy County Medical Society met May 13th at Morris. The meeting took the form of a banquet at the Commercial Hotel.

The banquet was in the nature of the first annual meeting of the recently organized society, and three well-known Chicago specialists were present and read interesting papers. Emil Reis read a paper on "**Rare Forms of Constipation and the Treatment**;" W. L. Baum



read a paper on "Diphtheria," and G. W. Webster read one on "Tubercular Peritonitis." The physicians present were: Dr. Bennett of Mazon, Dr. Brock of Coal City, Dr. Brinkerhoff of Minooka, Dr. Hannawalt of Lisbon, Dr. Frank Palmer of Gardner, Dr. Pickles of Coal City, Dr. Nelson of Morris, Dr. Ferguson of Morris, Dr. Palmer of Morris, Dr. Walsh of Morris. The next meeting of the Society will be held during the summer at Mazon. An election of officers was held and Dr. Bennett was chosen as president, while the following were re-elected: Dr. Brock, vice president; Dr. Ferguson, secretary; Dr. Walsh, treasurer; Dr. Nelson, trustee.

H. M. Ferguson,  
Official Reporter.

The Southwestern Medical Society of Chicago held its 20th regular meeting at Grace Cafe, 540 West 63d street, Tuesday evening, May 13th.

There was an attendance of 34, and a number of new faces were noticed.

Several new names were received for membership. The minutes of previous meeting read and approved. C. H. Miller, president, called upon F. C. Eggert, who presented a case of **Aneurysm of Arch of Aorta**, in a man who had been very much benefited by the injections of gelatine solutions during the past three years.

The regular paper for the evening, **Pain in the Ear**, was then read by H. Kahn. This paper proved to be one of the most interesting and instructive we have had and was ably discussed by Drs. Miller, Eggert, Rose, Hecht, Lovewell, Hagens, Weir, Chichester, McGonagle, Leinen and Avery. The question of delegates to State and National Medical meetings was then taken up and it was unanimously agreed to send Chas. H. Miller, president.

The meeting for June was announced to be a clinical meeting.

Thos. C. McGonagle,  
Official Reporter.

The Mercer County Medical Society. Physicians from various parts of the county assembled in the county court room, Aledo, on April 17th in response to a call which was issued to every regular physician residing in the county. Eight were present, who were in full accord with the spirit and intent of the State Society. After a general discussion, in which all present participated, it was unanimously voted that an organization be immediately effected.

George Irwin was chosen temporary chairman. A. N. Mackey was chosen temporary secretary.

On May 8th, when the house was called to order by Geo. Irwin, those present were as follows: T. C. Hainline, H. H. Fletcher, V. A. McClannahan, M. G. Reynolds, C. W. Carter, Geo. Irwin, I. S. Hamilton, C. T. Lytle, A. P. Willetts and A. N. Mackey. After the adoption of the constitution and by-laws, it was voted to effect a permanent organization. The following officers were elected: M. G. Reynolds, president; H. H. Fletcher, vice-presi-

dent; A. N. Mackey, secretary and treasurer. Board of censors, A. P. Willitts, V. A. McClannahan, T. C. Hainline.

C. W. Hall, of Kewanee, was present with us and delivered an able and instructive address on **The Benefits of Medical Organization**, and was highly appreciated by all present.

Delegate and alternate to the State Convention, V. A. McClannahan and J. S. Hamilton.

A. N. Mackey,  
Official Reporter.

The Fulton County Medical Society met for its eighteenth bi-monthly meeting in the Masonic hall in Fairview, May 6th. Called to order at 10 a. m. by President Stoops.

Minutes of the two previous meetings were read and accepted.

G. S. Betts' application for membership was reported upon by Regan and Sutton. Sutton moved its acceptance with dues paid to Jan. 1st, 1903. Carried.

Dr. Robinsons' application was not acted on because committee had failed to report.

President appointed Fraser, Sutton and Regan to select next meeting place.

Adjourned for dinner.

1:30 p. m.

Called to order by President Stoops.

Regan moved courtesies of the society be extended to Dr. Beaty and he invited to participate in the proceedings. Carried.

Committee reported Lewiston as the next meeting place. Report adopted.

The following papers were read:

**Apoplexy**, by Dr. Sutton.

**Etiology of apoplexy**, by Dr. Ray.

**Phlegmasia**, by Dr. Frazier.

Adjourned to meet in Lewiston July 1st, 1902.

D. S. Ray,  
Official Reporter.

The Alton Medical Society met in regular monthly session on Thursday night, April 10, with the following members present: Cook, Davis, Ash, Halliburton, Wilkinson, Worden, and Yerkes. Homer W. Davis read the paper of the evening on, "**Tubercule in the treatment of Tuberculosis**," and said, in part, as follows:

Tubercule is at present of little practical importance. Its use is advised by its advocates, for the most part, only in the favorable surroundings of the sanatorium. It was first discovered by Koch in 1890, and since that time it has been modified by many of its users.

When a small dose of tubercule is injected into a healthy animal, one physiological effect is observed. If the dose be increased, a feeling of malaise occurs with accelerated pulse, slight elevation of temperature, and perhaps a slight cough. In doses sufficiently large, it is possible to cause death—3 c. c. to 5 c. c. of the common tubercule being necessary to produce death in a guinea-pig weighing 300 to 450 grammes. (Fitch).

Upon tuberculous animals, however, the effect is quite different. The injection of a few milligrammes causes an intense febrile reaction and may even prove fatal. This power of the small dose is used for diagnostic purposes in cattle and also upon the human beings. In ad-



dition to this general ferbrile reaction, if there be external tuberculous lesion, a local reaction may be observed to take place.

Those who have made the most thorough study of the subject and practice tuberculine therapeutics most extensively are the most outspoken in its favor. We believe that the treatment is gaining favor among the profession in general and the time will come when it will be recognized as an essential part of the therapy of tuberculosis in properly selected cases.

Geo. E. Wilkinson,  
Official Reporter.

The **Marshal County Medical Society** met in regular session at the Library building in Lacon, Tuesday May 13, at 2 p. m.

On account of stormy weather a number of members living at a distance were not present.

The meeting was called to order by the president, E. S. Everett.

Minutes of last meeting were read and approved.

The following names were presented for membership and were acted upon favorably by the board of censors: B. F. Forrest, W. H. Jones, I. N. Smith.

The papers were taken up in the following order:

**Report of a case of Diabetes Mellitus**—L. G. Thompson, Lacon.

Discussion led by E. S. Everett and participated in by all present, including the venerable Robt. Boal, of Lacon, who is now 96 years of age and who entered into the discussion of all the papers with as much vim as any of the younger men present.

**An Obstetrical Experience.**—W. H. Jones, Henry.

Dr. Jones reported a case of inversion of the uterus with several unusual features, which were of interest and which were fully discussed.

**Immediate Legislation needed for the Protection of the Physician.**—B. F. Forrest, Henry.

Dr. Forrest showed the loop holes through which the traveling quack could escape paying a fine or imprisonment under the existing statutes and showed the necessity of amending the laws to meet the demands of the day. He urged the members to endeavor to interest the state legislators in the subject. He cited numerous personal experiences in dealing with quacks, as an officer of a municipality.

All present were in hearty accord with the speaker and expressed a desire to assist in bringing about the needed protection.

An amendment to the constitution was proposed and received its first reading.

This amendment provides for admission to membership in the society of any physician who is licensed by the State Board of Health, who is in good moral and professional standing in the community in which he resides, and who does not practice, or advertise to practice, any exclusive dogma or system of medicine.

S. O. Hendrick, of Henry, was appointed as delegate to the State meeting at Quincy.

On motion the meeting adjourned to meet at Lacon on Oct. 14.

Walter G. Du Four,  
Official Reporter.

The **Chicago Gynecological Society** met March 21st, President L. E. Frankenthal in the chair.

C. S. Bacon exhibited a case of **exancephalus**. The child, female 30 inches long was deadborn.

Gustave Kolischer exhibited a **retractor for use in laparotomy**.

C. S. Bacon read a paper on **Massage of the breast during lactation**. Quotations were given from various text books to show the common teaching of breast massage is faulty, being founded on incorrect principles. The universal direction to rub the breast from the circumference toward the nipples has evidently for its object the emptying out of the overfull milk ducts. As a matter of fact painful distention of the breast, which is the indication for massage, is not due to the presence of a large amount of milk but to over filled blood and lymph vessels. This is proved by the fact that the distention can be relieved by massage that empties the vessels without removing a drop of the milk. There is no danger of stagnation or curdling of milk in the breast.

The veins and lymph vessels of the breast empty into the axilla and subclavian vessels. Massage, which should aim to empty the breasts of their excessive blood and lymph supply, must be made in the direction of these efferent vessels. Detailed rules were given for carrying out such massage.

The paper was discussed by Dr. De Lee who agreed with the principles of the method. Drs. Kolischer and Frankenthal doubted whether considerable milk was not formed during the interval between nursings. Drs. Earl and Doering agreed with the essayist.

April 18.

The President L. E. Frankenthal in the chair. J. B. DeLee reported a case of **Caesarian section**, which was discussed by Drs. Kolischer and Watkins.

C. S. Bacon exhibited a case of **ofanencephalus**. A. Goldspohn exhibited a specimen of **fibroid tumor of the broad ligament removed with the uterus**.

Samuel Weber reported a case of **dystocia**. After labor had lasted two or three days during which time the patient had suffered much from dyspnea, Dr. Webber was called and found hydramnion with dilated cervix. He ruptured the membranes and waited till the labor seemed to progress favorably when he left the patient in charge of other attendants. Later he was again called and found a brow presentation. This was finally delivered with forceps. The management was criticised by Drs. Kolischer and De Lee.

A paper on **spinal anesthesia** was then read by Dr. Weber. The paper was based on his own experience in one hundred and fifty cases. In about three thousand cases, twelve deaths have been reported. Few or none of these deaths were due to the anesthetic itself. Failure to produce anesthesia is due either to failure to penetrate the spinal canal or to an unreliable solution. The writer gives directions for making a solution and injecting it. He concludes that the method is valuable in cases where general

anesthesia is contraindicated for operation on the lower extremities and in the pelvis, for hernia and many obstetric operations.

The method was criticised by Dr. Kolischer who held that it was much more dangerous than general anesthesia. C. S. Bacon and Dr. Pierce held that further investigations with the method under proper precautions were justified.

C. S. Bacon,  
Official Reporter.

The Chicago Gynecological Society met May 16, 1902, President L. E. Frankenthal in the chair. These transactions and papers are published in full in the American Journal of Obstetrics.

T. J. Watkins presented a specimen of a very large myxosarcomatous tumor which nearly filled the pelvis and abdomen. Bacteriological examination showed it to be sterile. The patient died however after about thirty-six hours. Dr. Watkins suggested that death may have been due to toxæmia from toxins of the tumor absorbed after its breaking down and removal.

L. E. Frankenthal exhibited a large tumor showing carcinomatous degeneration of a uterine fibroid which was removed post-mortem. An exploratory incision had been made, but on account of the adhesions no attempt was made to remove the tumor. The patient died suddenly a few hours after the operation.

Franklin H. Martin exhibited a specimen of a sac of extrauterine pregnancy which contained the remains of a fetus that had been dead two years.

A. Goldspohn exhibited a specimen of carcinoma of the abdomen wall in the region of the scar made by an operation for gall stones two years before. Some omentum and liver were removed.

Rudolph Holmes exhibited a new instrument for dilating the cervix during labor. It consists of hard rubber half cylinders of different sizes to be attached to the ordinary Ellinger dilator.

Jos. B. De Lee presented a needle for use in injecting normal salt solution. Its advantages are that it has a handle and consists of a single steel tube not jogged, with lateral openings. It also has a ventilated guard.

T. J. Watkins reported a case of ovarian cyst complicated with infection by the pneumococcus and staphylococcus albus. The cyst which was a large one was removed with the uterus that contained a fibroid. It seemed carcinomatous, but examination showed the presence of staphylococcus and probably pneumococcus. The abdominal wound became gangrenous and allowed the intestines to be exposed on the fourth day. The patient died the fifth day.

J. B. DeLee reported a case of coli communis infection following a cleaning out of the uterus after attempts at a criminal abortion. Examination of the contents of uterus showed the colon bacillus. The patient recovered.

A. Goldspohn then read a paper on What are the known facts about follicular cystic degeneration of the uterus? He reviewed the work of the various investigators and showed that the fact is now well established that the degenerat-

ed cysts are pathological and contain no ova. Because of this and because the degenerated ovaries produce pathologic symptoms Dr. Goldspohn resects or removes them when making other operations in which they are exposed. Dr. Emil Ries held that a slight pathological change did not constitute a clinical indication for operation and condemned the practice of operating on cystic ovaries.

Fernand D. Henrotin read a paper entitled The Operation for Fibroids. He favored removal of the tumor or tumors first and then removal of the uterus if necessary but saving it if possible. The paper was discussed by Drs. De Lee and Ferguson.

C. S. Bacon,  
Official Reporter.

The Adams County Medical Society met April 14th, 1902, Vice-President W. W. Williams in the chair. Minutes of the last meeting read and approved. The petitions of L. F. Worley, Lima, and W. E. Miller, Columbus, for membership in this society were read.

The board of censors reported favorably on the names of J. M. Grimes, Camp Point, J. T. Spence, Liberty and E. H. Toole, Quincy. At the subsequent ballot Grimes and Spence were unanimously elected, Toole being rejected.

A committee "for the good of the profession," was elected to be composed of Hart, Riticker, and Gilliland.

J. D. Justice reported a case seen by him as follows: On the evening of Jan. 5th, 1902, was requested to see with J. W. Edward Bitter, a woman of healthy German parentage, of 39 years, in labor for the first time of some 12 hours duration. He expressed his opinion that nothing short of a Caesarean section would save his patient's life. Examination revealed a flattened tilted pelvis due to an old but now stationary scolioma at the bifurcation of the aorta, an unobliterated cervix that barely admitted the index finger.

The terrific contractions and failing strength of the woman made quick interference imperative. Being landed in St. Mary's hospital and hastily prepared for a section, the gravid uterus was brought through a median incision and by anterior linear cut the child was released. All blood being staunching by an elastic tourniquet about the cervix, the placenta was easily scooped from posterior wall and fundus. The uterus rapidly reacted under hot towels and by a continuous suture of catgut its decidua was closed.

The walls were stayed with silk and the peritoneum with uninterrupted sutures of animal tissue, while the muscles, fascia and skin were coapted with continued sutures of silk. Other than a stitch abscess her recovery was uneventful and rapid.

Resuscitation of the asphyxiated infant was begun the moment of release, but was only partially successful.

It was a female and well developed. The mother claimed it to have been a 10 months babe.

The Fritsch incision was not applicable in this case on account of placental attachment.

A so called elective case could have been



done, had her physician been consulted any-time previous to ushering in of labor, instead of several hours after.

The statistics of Erb are of value in the matter of mortality reasons.

In his collection there are 13 women operated on before labor with a loss of but two mothers.

Six cases at the beginning and all saved; 12 cases when labor had lasted two or six hours, 10 women and 11 children recovered. Eighteen cases when labor had been on for 9 to 12 hours, eight mothers and 13 children lived, which teaches the lesson the late operation is to be avoided.

Prominent among the indications for the classical caesarian section are the contracted pelvis, eclampsia and cancer of cervix.

The dwarf of 39 years has nothing remarkable in her family history except that while in utero her mother was badly crippled by rheumatism, her hands and feet being severely contracted. At birth the subject of the present report was congenitally deformed in both hands and feet.

From the knees down the bone shafts are shortened and twisted and dwarfed also the hands are deformed, fingers all more or less ankylosed and dwarfed. Otherwise of good form and healthy.

The child had not a blemish.

Discussion followed by Drs. Hatch, Koch, Nickerson and Christie, Jr.,

Dr. Ashton presented a case of **Herpes Zoster Ophthalmicus**, the lesion following the distribution of the ophthalmic division of the trigeminal nerve on the left side, involving the left side of the nose, the brow and scalp back as far as the vertex. The cornea also had become invaded through its ciliary branches producing an ulceration so extensive and painful as to demand an exision of the eyeball, which was done. The case proved of some interest because of the rarity of this disease and its intractability to medical treatment.

Members present: Nickerson, Hatch, Rice, Justice, Christie, Jr., Center, Bierne, Vasen, Knapheide, Brenner, Collins, Koch, Riticker, W. W. Williams, Asheton and Hart.

Meeting adjourned.

Henry Hart.  
Official Reporter..

The Adams County Medical Society met May 13th. It was the annual meeting. Added interest was taken in the meeting owing to the near approach of the meeting of the State Medical Society, which convenes in Quincy, May 20 to 22. There were over thirty doctors present in the meeting. After the usual reports were received and approved the society elected the following officers for the coming year:

President, W. E. Gilleland, Coatsburg; first vice-president, E. B. Montgomery, Quincy; second vice-president, J. D. Justice, Quincy; secretary, J. A. Koch, Quincy; treasurer, L. H. A. Nickerson, Quincy. Censors, D. M. Knapp, Mendon; O. F. Wellenreiter and H. P. Beirne, of Quincy.

John A. Koch,  
Official Reporter.

The Chicago Laryngological and Climatological Association held a regular meeting April 21st, in the Schiller building, with the president, Moreau R. Brown, in the chair.

John Edwin Rhodes reported (1) A Case of Probable Congenital Heart Disease; (2) A Case of Aneurysm of the Aorta of About 40 Years' Duration.

**A Case of Probable Congenital Heart Disease.**

Constance D., 11 years old, was brought to the clinic at Rush Medical College by Dr. Brannan. Her mother and father are living. There have been 9 children in the family, all of whom are living and well, except herself and one other child who died from hip disease from an injury. She weighs 60 pounds; is well nourished, lips red, skin of a healthy normal color and temperature normal. She had an attack, which was diagnosed German measles by her physician, when she was 3 years of age, followed by double pneumonia, and she has had several attacks of pneumonia since. She has never had an attack of rheumatism. Her mother says that she was never as strong as her other children, but she gives no history of cyanosis at birth or subsequently, although she says that her color was not as good as that of the other children. The child says that as long as she can remember she has been somewhat short of breath on exertion, as in walking fast or going upstairs, but it seems to be no worse now than it has been for some years past. She has always a loose, hacking cough, at rather frequent intervals, with occasionally expectoration of a small amount of mucous, except when she has an acute cold when it becomes yellow. She has occasional dizziness. She has infrequent frontal headaches. There is no pain or tenderness over the chest. She often has palpitation when tired or excited, the heart's action then being much accelerated. I found her pulse 104, rather weak, but regular; respirations, 22; temperature on one occasion was 99½°, but usually is normal. Her blood count shows 5,300,000 red corpuscles, white corpuscles 17,000. The tongue is clean; the appetite is good; the digestion is good and the bowels are regular.

The superficial veins of the chest are quite prominent; slight pulsation of carotids, especially of the right at the sternal notch, but no venous pulsation. The thyroid is slightly enlarged. The skin on the arms is dry and harsh, but this is not the case with the skin covering the trunk of the body. There is no cyanosis, except a slight duskiness of the finger nails. There is no clubbing of the fingers. The impulse of the heart's apex is in the 5th intercostal space, ½ inch outside of the mammillary line and is about 1 inch in diameter. An impulse is also seen at the base of the left border of the sternum in the 3d intercostal space. No thrill is felt over the apex. Over the upper portion of the precordia as far out, on the left side, as the anterior axillary line in the 2d and 3d intercostal spaces and with diminishing force as high as the clavicle a thrill is felt. It is felt in its maximum intensity in the 2d intercostal space 2 inches from the median line. The thrill is not perceptible to the right of the sternum palpa-



tion. There is no bulging of the precordia. Dullness on the left side begins at the 1st rib and extends downward to the 6th. Dullness to the right extends  $1\frac{1}{2}$  inches from mid sternal line in 3d and 4th interspaces. Dullness to the left extends  $1\frac{1}{2}$  inches from mid sternum in 1st interspace  $2\frac{1}{2}$  inches from mid sternal line in 2d and 3d interspaces, 3 inches in the 4th interspace, and  $3\frac{1}{2}$  inches in the 5th. On auscultation at the apex there is no distinct murmur, but a slight systolic roughness which is not transmitted. Over the base of the heart a loud diastolic and a systolic murmur are heard distinctly in the pulmonary area and they are heard very distinctly at the left border of the sternum in the 2d and 3d intercostal spaces, the systolic murmur being more distinct in the 2d intercostal space about 2 inches to left of sternum. These murmurs are not apparently transmitted to the arteries of the neck nor are they heard behind. The second pulmonic sound is very markedly accentuated. There is no accentuation of the second sound in the aortic area nor are there murmurs in this area. No venous hum is heard at the base of the neck. There are no evidences of tumor in the pulmonary area.

In this case we probably have an obstruction and insufficiency at the pulmonary orifice with hypertrophy and dilation of the right ventricle. There is probably also an hypertrophy of the left ventricle and dilation and hypertrophy of the left auricle with intrapulmonary obstruction to account for the accentuation in the second pulmonic sound.

#### A Case of Aneurism of the Aorta of About 40 Years Duration.

Mrs. W. H. S., aged 50, married. Her maternal grandfather had rheumatism; some second cousins of the mother died of phthisis; the mother died at the age of 44 of some disease, the nature of which she does not know, otherwise her heredity is negative. She had scarlet fever at the age of five and also had measles in childhood. She has never had rheumatism and gives a history of no other illness of any importance. She is of medium height, weighing 148 pounds; 5 years ago her weight was 185. She has never had children or miscarriages. Her pulse is 86; that at the left wrist being somewhat stronger than that at her right. Her strength at the present time is not very good. The hearing of one ear is somewhat obtunded, probably due to the attack of scarlet fever. She has frequent headaches. She has an occasional slight oedema of the ankle but has never had this to any marked degree. She has dyspnoea on slight exertion and is occasionally conscious of shortness of breath when quiet. She has been able for years, however, to go about her ordinary duties without much difficulty; of late, she has suffered somewhat more than usual from dyspnea on exertion, as in putting coal in the furnace, etc. The respirations are not much accelerated; her appetite is good, but the digestion is not good; the bowels are regular. She complains of occasional very marked throbbing of the arteries all over the body. She is complaining of numbness lately in the back part of the throat and

tongue and occasionally suffers from palpitation after eating. She states that when she was a child she was in the habit of jumping a rope to great excess and to this overexertion she attributes her trouble. She says that she knows that she has had this affection of her chest for 40 years. Over 21 years ago she was seen by Dr. Austin Flint, Sr., Dr. Janeway and others in New York and a diagnosis was made of aneurism of the aorta and she was shown to the students in classes at Bellevue and elsewhere.

On examination of the chest, we found on the first interspace on the right there is no dullness. On the left side of the sternum the resonance is normal and there is no bulging. There is a slight bulging over the sternum at the second rib more marked to the right than to the left. At the second rib there is dullness one inch to the right of the sternum, third rib, two inches, fourth rib, one inch, at which latter point there is some tenderness. A thrill is felt in the second interspace on the right over which area pulsation is felt and seen. The thrill is felt two inches to the right of the sternum and about one half inch farther to the right than the area of actual dullness. The apex is in its normal position. On auscultation a loud systolic murmur is heard all over the left side of the chest increasing in intensity into the aortic area. In the aortic area systolic and diastolic murmurs are heard and a systolic shock is present. The systolic murmur is loud over the upper part of the chest but more marked in the second and third intercostal spaces of the right side. This murmur is also heard over the carotid and behind at the right side of the spine from the apex to the fourth dorsal vertebra. An interesting feature of this case is that the patient has been able to pursue her usual avocations for about 40 years and there has evidently been very little increase, if any, in the size of the aneurism, and she has suffered very little from such symptoms as one with such a lesion might ordinarily be expected to have.

**William E. Casselberry:** I am a little surprised, if it be an obstructive lesion of the pulmonary orifice, that there should not be disclosed more hypertrophy of the right ventricle. This does not appear to be prominent either in the skiagraph or by percussion in the subject. Also, there is quite a pronounced hypertrophy of the left ventricle, and at the apex, whilst the same loud systolic murmur, which is audible in the pulmonary area and to the left of the pulmonary area, is not transmitted to the apex, as Dr. Rhodes has said in his paper, there is still at the apex another systolic sound very like a rough murmur, but not so loud. It would seem to me the diagnosis as made is probably correct, as far as it goes. It is necessarily made largely by the exclusion of the typical evidences of other lesions, and yet subsidiary murmurs indicate the probable presence of a more complex condition.

**E. Fletcher Ingals:** The case of the little girl is very interesting, but as Dr. Rhodes has suggested, there is no way of telling absolutely by the physical signs the exact condition which causes the signs. The history and the systolic

murmur heard at the base of the heart which is not transmitted to the left or to the arteries, is indication of a communication between the auricles or between the ventricles; yet the character of the murmur, and the sudden sharp closure of the pulmonary valves would seem to indicate that the sound is produced at the pulmonary orifice.

The woman with aneurysm, presents a unique history of the development of an aneurysm of the aorta very early in life, and of its having persisted nearly forty years without serious disturbance. Fortunately, we have the report of examinations made by skillful men thirty years ago, and the physical signs today certainly indicate an aneurysm.

The occurrence of aneurysm in children is extremely rare, and there is nothing to account for it in this case excepting the exertion from jumping the rope.

**A. M. Corwin:** In regard to the case of the little girl, shown by Dr. Rhodes, it is one of those interesting instances of heart lesion, the signs of which are seemingly at variance with the rules which one finds laid down in our textbooks and about which it is unsafe to dogmatize, and therefore Dr. Rhodes is wise in qualifying the terms of his diagnosis. At my examination I made out the seat of the chief murmur at the fourth left intercosto-sternal junction, over the ordinary tricuspid area. It is diastolic in time. It is not well transmitted to the left side of the heart, being feeble at the apex. The absence of aortic regurgitation, and of all the classical signs and symptoms of that affection, would rule out aortic leakage as a cause of this diastolic murmur. The murmur is more of the type of that produced by mitral obstruction in some respects, but unlike the usual obstructive murmur in that it lasts seemingly throughout diastole, not, as is usually the case, confined to the latter part of the ventricular diastole, corresponding to auricular-systole. In this case it lasts throughout diastole. The small caliber of the pulse would seem to suggest the presence of an obstructive lesion in the left side of the heart. In the absence of the signs of aortic obstruction, and with this diastolic murmur, we might suspect the lesion to be mitral obstruction. This supposition is strengthened by the accentuated pulmonic sound and the clear and loud mitral first sound, and also by the enlarged left auricle, shown by clinical dullness, and by skiagraphic duskiness of that area. The signs of tricuspid obstruction, which is a rare affection, are absent in this patient. In such a case, we should expect enlargement and hypertrophy of the right auricle, whose presystolic action might be seen and felt, and also systemic venous engorgement with presystolic pulsation in the jugulars, corresponding to powerful right auricular contraction. The pulmonic second sound would be apt also to be feeble from relative lowered pressure in the pulmonary circuit. It would seem to me, then, that there is a mitral obstructive murmur in this case, with an unusual seat.

**Dr. Rhodes** (closing the discussion): In making a diagnosis, of pulmonary obstruction and regurgitation, I have done so largely by exclu-

sion. We have here two murmurs, one that is distinctly systolic, and the other takes up the entire time of diastole. If we had a diastolic murmur at the mitral valves, it would be apt to be a presystolic murmur at the latter part of the diastole and be heard distinctly in the mitral area. The murmur is not heard in the mitral area as the mitral. The thrill of mitral stenosis is presystolic. The thrill here is systolic and is not felt in the mitral area. A tricuspid diastolic murmur would have the same time and rhythm, and it would be apt to be a presystolic murmur. We would have epigastric pulsation. But there is no such evidence here. The right side of the heart is enlarged, but not markedly so. It is an anomalous condition, and we cannot say that the only lesion is located at the pulmonary valve. We certainly have enlargement of the left side of the heart, and that accounts for one of the features I spoke of, namely, accentuation of the second pulmonic sound heard distinctly in the pulmonary area. If the disease were confined entirely to the right side of the heart, we would have no accentuation of this second sound. The case is puzzling, because some of the cardinal symptoms are absent. In most of these cases we have, according to most authors, cyanosis. There is no evidence of cyanosis here except a slight duskiness of the finger nails. Then, too, we have absence of clubbed fingers, which is a common sign in cases of congenital pulmonary disease. So I have had to arrive at my conclusion largely from the seat of the murmurs and other signs elicited by physical examination, and the exclusion of other lesions. Whether we have also a patent septum or ductus arteriosus in addition to the pulmonary lesion it would be practically impossible to determine.

In the determination of the question as to whether the lesions were congenital or acquired—as might be possible at the time of the attack of an infectious disease when the child was then three years of age—I have arrived at the decision of congenital disease from the fact that congenital lesions at this valve are not uncommon, and the right side of the heart is the one usually involved. Pulmonary obstruction is usually accompanied by incompetency in congenital disease. It would be a most unusual occurrence to have these valves selected for involvement in an acquired endocarditis. It is quite possible, I suppose, that the attack of German measles may have caused further disease in an already crippled heart and the condition of the left auricle and ventricle may have dated from that time. However, the appearance of other lesions in the subsequent history of congenital heart disease is a common occurrence.

#### Fibrosarcoma of the Soft Palate and Tonsil, with Exhibition of Pathological Specimen.

**Charles M. Robertson:** The patient, Mr. C. S., farmer by occupation, sixty-two years of age, while picking his teeth with a straw, pricked the left tonsil, causing a little pain at the time but not enough to pay special attention to. In a few days he noticed a small swelling above the left tonsil which increased rapidly in size



till the end of eight weeks when he presented himself at my clinic for relief. At this time the patient experienced great difficulty in breathing and it was almost impossible to swallow food. Upon examination a large tumor was found occupying the left palatal arch, well down to its base involving the tonsil and side of the pharynx as far as the epiglottis, and up behind the edge of the hard palate as far as are left Eustachian tube. It extended forward into the mouth to within one inch of the incisor teeth. The growth was smooth in contour, lighter in color than the surrounding tissues, and firm and elastic to the touch. Under cocaine, a piece of the growth was removed for microscopical examination and pronounced Fibrosarcoma. The following week the patient was operated, under chloroform anaesthesia and the growth removed. It was found to be encapsulated and on this account a favorable prognosis was made. You will note the tonsil upon examining the specimen and see that it is attached to the growth at a little below the center. In looking over the literature I find some 25 cases reported of sarcoma of the soft palate and 45 additional cases of sarcoma where the soft palate and tonsil or tonsil alone was involved. In nearly all the cases the growth was removed by external operation and in these cases recurrence was frequent whereas the encapsulated growths removed by the mouth were not so prone to recurrence. The case under consideration has as yet shown no signs of new growth, twenty months having elapsed, and therefore I feel justified in reporting it as a cure.

**E. Fletcher Ingals:** The tumor presented by Dr. Robertson recalls to my mind a case that presented itself at the clinic of Professor Gunn, when I was a student. This tumor almost filled the mouth and throat, so that the patient had great difficulty in breathing. Professor Gunn succeeded in enucleating the tumor with his finger in about a minute. It was about three and a half inches in length and two inches in diameter, resembling a goose egg closely in shape and size.

Dr. Casselberry's patient recalls the case of a boy of 13, upon whom I operated and removed a fibro-sarcoma in 1883, through the natural passages. The tumor soon showed a tendency to recurrence, but as the patient was in the city alone and fell into bad company, I was obliged to send him to his home, in a distant state. He came to see me again sixteen years afterward for pain in the chest, apparently of rheumatic origin. He stated that after returning to his home the first time the tumor had grown so as to cause complete nasal obstruction, and great prominence of the right cheek, and to destroy sight in right eye, but after a few years it had almost completely disappeared by atrophy. The cushion-like mass in Dr. Casselberry's case appears to me a recurrent tumor.

**A. M. Corwin** reported **A Case of Carcinoma of the Epiglottis.**

Here is a man 66 years old. He was a captain in the civil war and bears honorable wounds, none of which proved of permanent injury. He has been married twice; his present wife has pulmonary tuberculosis which

has been manifested in its various stages even to marked cavity formation, and has been variously active or quiescent for the past six or seven years, during which time she has been under my care. Her brother died of tuberculosis within the past two years and resided at this patient's home during his long illness of a year or more. So if the dangers of contagion are vital in such cases, this patient has had more than ordinary opportunity for contracting the disease. He has, however, been of robust health up to recent years, since 1895, when he has had attacks of epilepsy several times annually, though none the past year. There is no history or evidence of syphilis. His family history is excellent. About three months ago he consulted me for throat trouble which he had noticed for three months as an uneasiness in the lower part of the pharynx, a slight feeling of fullness, stiffness and increased secretion which required frequent clearing of the throat. There was little or no pain except some dysphagia beginning about six weeks before he came to me. His voice was clear and he had no cough. Examination showed nose and fauces normal. The epiglottis was slightly congested but not swollen or otherwise abnormal except along its left margin from tip to base. Here there was a proliferative ulcerated surface which projected above the normal surface of the epiglottis as a cauliflower-like formation covered by a grayish muco-purulent secretion. When this was removed by swab the surface was seen to be granular though it did not bleed except after considerable violence. The side of the tongue and the adjacent wall of the pharynx which were most of the time in contact with the growth, presented a similar granular ulcerated surface which also involved the aryepiglottic and pharyngo-epiglottic folds. Considering the character of the morbid area and the extent of the surface involved, the absence of swelling of the neighboring tissues and the absence of glandular enlargement was noteworthy. The larynx and trachea were otherwise normal. Gravitation of secretion of the morbid growth into the larynx requires occasional clearing of the throat. Examination of the chest showed lungs normal and heart substantially so, except for slight enlargement and accentuation of the aortic sound which accords with the high tension and well marked sclerosis manifest in the superficial arteries. There is also persistent albumenuria with tendency to low specific gravity and a moderate number of granular and hyaline casts in the urine. Thorough examination of the sputum and scrapings of the epiglottis show absence of tubercle bacilli or other significant morbid elements. The local appearance of the duration the absence of pain, the absence of lung and sputum findings and lack of emaciation and normal temperature and pulse rate ruled out tuberculosis. In view of his having been in the army because of the absence of pain usually more or less present in tuberculosis and cancer of the throat, he was put upon increasing doses of iodides up to 40 grs. t. i. d., which seemed to be the maximum for him. This was administered cautiously because of



the kidney findings and was continued for several weeks without benefiting his throat in the least or harming his damaged kidneys so far as can be seen. The case is, therefore, one of malignant trouble (carcinoma) a small piece was taken from the diseased area with punch forceps revealed the characteristics of granulation tissue, but was so small as to be unsatisfactory in demonstrating carcinoma tissue. There seems to have been slightly more rapid degeneration of the point or removal, so that I have considered that nothing would be gained by further ante-mortem histologic investigations because of the contra-indications to radical operation in the case, because of the extent of involvement, the age of the patient, his arterio sclerosis, his chronic nephritis and epilepsy. A good specimen will be obtained post-mortem. The progress in the last three months has been slow and it is about an eighth worse than when I first saw him two and a half months ago. He has been upon a forced milk diet with starchy foods judiciously chosen and nitrogenous food avoided. It is somewhat remarkable that he has retained his weight. Local measures have been directed to cleanliness chiefly.

#### Case of Leukoplakia Buccalis, Treated by X-Ray.

**Otto J. Stein:** The case I have is one that was presented to the society four months ago, it being one of leukoplakia buccalis. I showed the patient prior to the X-ray treatment, promising to show the case again after this treatment, and thought it might be interesting because I know of no such case having been treated by the X-ray. After four months' trial of daily treatment, we ought to expect a favorable or unfavorable result. The patient was treated daily for two months, with very little improvement. Dr. Pusey then asked to continue the treatment, which he has done for two months more. The patient is here now, and I would like you to notice the difference in his condition now and four months ago. At that time the case showed a hornified excrescence on the mucous membrane in front of the ramus of the jaw on the left cheek, with large plaques on the inside of the angle of the mouth. This hornified area was resected, and proved to be an epithelioma. This is not improved, but instead covers about three times its former area. The patient at present has very little inconvenience in swallowing or from any pain. I think four months' trial is quite sufficient for the application of the X-ray to demonstrate whether it will do any good or not.

#### Resection of the Superior Maxilla for Fibrosarcoma.

**William E. Casselberry:** This case is one in which a unilateral resection of the superior maxilla has been made on account of intranasal fibrosarcoma. The operation was done at Wesley hospital by Wel'er Van Hook, the surgeon in charge, assisted by myself, and was preceded by ligation of the external carotid artery. I present the patient chiefly to demonstrate the degree of deformity which results from the removal of the superior maxillary bone. The deformity, so far as the facial aspect is concerned,

is not as great as one would expect. As you will observe, the incision was made from below the orbit around the nose and through the lip, the flap dissected back, and the left maxilla, including the teeth, removed. The man's cheek, however, still has a reasonable prominence. The facial deformity, however, does not represent all the inconvenience which has followed the operation. Union has failed along the line of the cleft in the hard palate, so that the patient practically now has an acquired cleft palate. Of course, this cleft of the palate can be closed by an additional operation, provided recurrence of the malignant disease does not take place. But for the time-being his speech is of the typical cleft palate type.

I first saw this patient last June. At that time he had a large tumor on the nasal fossa which projected anteriorly. The front portion presented a granulating surface, bled freely, and had the appearance of sarcoma. The growth projected posteriorly, also filling much of the naso-pharynx. There was exophthalmos and prominence of all that side of the face. The diagnosis was fibrosarcoma, and this was subsequently verified by microscopic examination. The situation of the growth and a shadow on transillumination led me to think the antrum was involved, and this was one reason why resection of the superior maxillary bone was decided on. When we came to shell the growth out, it was disclosed that the antrum was not directly involved, but that its nasal wall was much displaced outward by pressure of the growth. It was a pedunculated tumor, which originated from the base of the sphenoid bone in a situation between the sphenoid sinus and the posterior end of the superior turbinated body. It had developed in two lobes, one growing posteriorly, and the other anteriorly. The growth was encapsulated, but the capsule had broken down in the anterior part of the nostril. I am still of the opinion that the operation was justified by the appearance and character of the growth, but more so on the supposition that the antrum was involved. Had I been able to determine that the maxillary sinus was not affected I would have advised a less extensive operation; that is to say, I should have favored either a temporary resection only of the superior maxilla, or an operation which would turn the nose over from one side to the other, together with the nasal bone and part of the articulating edge of the maxillary bone, which, with division of the soft palate, might have given sufficient space for evulsion of the growth. There is, as yet, no definite evidence of recurrence, although the tissue which has partly filled in the space of the cheek bone does not look entirely natural.

Another hazard of the operation concerns the necessity of ligating the common carotid, or at least the external carotid, artery, in order to control hemorrhage. Following the operation this patient became paralyzed on the right side, and the paralysis has persisted somewhat, but it is gradually becoming less. Inasmuch as the line of ligature of the external carotid is very close to the common carotid, the paralysis might have occurred from a clot going through the common carotid as an embolus.

George E. Shambaugh presented a **Specimen of Concha Bullosa**.

A specimen of a median sagittal section of the nose was exhibited, showing a large bone cyst in the anterior end of the concha media. The cyst had thin bony walls and was lined with smooth mucous membrane. It measured 28 m. m long and 25 m. m. broad, and presented an empty, air-containing cavity which communicated freely with the middle meatus, with the frontal sinus, with a large ethmoid cell pushed into the frontal sinus, and with the ethmoid labyrinth above and behind. The concha bullosa, or cystic enlargement of the concha media, is usually found as an empty air-containing cavity, but occasionally it is found the seat of a mucocele or an empyema.

A condition of circumscribed necrosis occasionally found in the concha inferior has often been confused with the true bone cyst, lined with epithelium, as found in the concha media. Such a cyst has never been found in the concha inferior, for the reason that this body is not a part of the ethmoid bone and is never the seat of an ethmoid cell.

The concha bullosa represents but an enlarged ethmoid cell. The concha media, like its analogous structure in the nose, unciform process and the bulla ethmoidalis, is often occupied by one or more ethmoid cells. The excessive enlargement of such a cell produces the concha bullosa. Such an enlargement may, in rare cases, be the result of an ectasia caused by the confinement of an inflammatory discharge in a cell, the outlet of which had become closed. But, as a rule, it is not associated with any inflammatory condition, and the enlargement should be looked upon not as a pathological product, the result of an inflammation, but as an anatomical variation, the result of a developmental anomaly.

#### **Operation for Deflection of the Nasal Septum.**

**Otto T. Freer:** My first patient is a woman upon whom I operated three weeks ago for an extensive cartilaginous and bony deflection of the nasal septum according to the method I described at the last meeting of this society. The resection extended from the nasal vestibule to within one-half inch of the posterior end of the vomer, and involved removal of a large part of the triangular cartilage, a small part of the perpendicular plate and a considerable portion of the vomer. The substance of the vomer was chiseled through above and below the bent part and the posterior end of this was severed with the trephine introduced on its hollow side after the mucosa had been separated and held out of the way with a cotton tampon. The deflection in the vomer was thus brought away entire. In my later cases I have substituted resection of the bony portions for the uncertainties of fracture, even with so good an instrument as the forceps of Roe. The pain inflicted by resection is less and the tissues are not injured by bruising. In the case shown tonight I made no perforation, sacrificed no mucous membrane and the flaps applied themselves perfectly and healed by first intention. I do not regard this as an exceptionally good result, but as the usual outcome of the resection operation. The patient

wore a tampon for four days, after that nothing was placed in the nostril and from the first she has had a roomy naris in place of one through which she could scarcely draw air with effort before the operation.

I have written out a careful history of the other case which I will now read.

#### **A Case of Phlegmonous Laryngitis Terminating in Abscess in Front of the Larynx, by Otto T. Freer, M. D.**

The patient, a man of 54, states that he never was ill until the beginning of the affection from which he has just recovered. After going to bed in perfect health on the 19th of February, he awoke in the night with his tongue so swollen that he could not close his teeth. At the same time he felt a swelling in his neck in the region of the larynx. He had severe dyspnoea from obstruction to breathing in his throat, and could hardly speak. These symptoms continued until March 2d, the stenosis slowly increasing. He was attended during the latter part of this period by William Bieringer, who informed me that he found no fever when he took the temperature. There was no chill at any time and the patient felt no pain. He could not swallow solids, but could drink slowly; if he drank fast he had a coughing fit, the liquid entering his larynx. I first saw him on March 1st at the Polyclinic. Examination showed the region of the larynx filled by a large tumor like mass that extended from the hyoid bone to below the cricoid cartilage. The lump was soft in its centre, pitted here on pressure and fluctuated obscurely. The lateral portions felt hard. Palpation caused no pain. Laryngoscopy was impossible as the tumified epiglottis was pulled down spasmodically by its depressors and touched the posterior pharyngeal wall, while its two sides folded together in the middle.

Suffocation seemed imminent on March 2d, so that I performed tracheotomy under cocaine anaesthesia. The incision had to reach from the hyoid bone to the sternum as the trachea was only accessible just above the sternum, necessitating a very low tracheotomy and because the pre-laryngeal abscess required a broad opening. The extensive and prominent swelling in the front of the neck made an unusually deep dissection needed to reach the trachea, so that the tracheotomy tube barely reached into the interior of the windpipe. The phlegmonous inflammation made recognition and separation of the anatomical parts hard, as it had matted the pre-laryngeal muscles and fasciae together. The abscess contained about two ounces of pus and was seated under the pre-laryngeal muscles in front of the laryngeal cartilages. It had a tough, thick anterior wall. The abscess closed in a week and the tumor-like swelling slowly disappeared so that in three weeks the neck felt normal, but the laryngeal stenosis increased so that for some weeks the patient could draw no air at all through his larynx. Inspection showed great swelling of the arytaeno-epiglottic folds and arytaenoids, and this combined with retraction of the epiglottis made inspection of the deeper parts of the larynx impossible. The



tracheotomy tube caused great irritation so that excessive amounts of mucus were coughed up. The swollen arytaenoids continued to make swallowing difficult, but on March 19th the voice began to return. On March 27th the epiglottis was lifted with a probe after cocaine had been applied, but the deeper parts of the larynx were still invisible because of the swelling of the upper larynx. On April 5th the cords could be seen and looked natural, but remained in a position of adduction, causing stenosis that made it impossible to remove the tube safely. The cords gradually separated so that on April 10th the tube was definitely taken out. The laryngoscopic appearance was normal, but there was still a tendency to retraction of the epiglottis and adduction of the cords.

The history of this case is that of one of the varieties of erysipelatous or phlegmonous inflammation not uncommon in the region of the pharynx and larynx.

The agents of septic inflammation enter the tissues through the lymphchannels of the mouth and throat with well-known frequency. Whether the milder form of erysipelatous swelling or phlegmonous inflammation ending in the formation of abscess will result, depends largely on the virulence of the infection, resistance of the individual and the formation of bubo in a lymphatic gland. In the latter instance a comparatively mild infection may result in abscess. The infectious agent in nearly all instances is the streptococcus pyogenes, which can cause both the phlegmonous and erysipelatous variety of inflammation. The identity of a specific streptococcus erysipelatosus has been disproven.

The place of infection and direction taken by the septic matter in the lymphchannels determines the site of the abscess, whether it will be a peri-tonsillar one, an angina of Ludwig, suppuration of the submaxillary glands, the carotid glands, a retropharyngeal abscess or as in this instance, an abscess of the prelaryngeal and pretracheal space, called also the previsceral space, situated between the larynx and trachea and the muscles in front. In my experience abscess formation in this locality is not very rare. I have seen four cases within the last few years. One of them was superficial, with no marked symptoms, the pus collected being localized in the thyrohyoid space. A second one occurred in a boy of eight who had a large abscess in front of the thyroid cartilages with voicelessness for weeks, laryngoscopic examination being impossible on account of resistance on the part of the child. Dyspnoea was absent. A third case presented no laryngeal symptoms, but began as an angina of Ludwig with hard swelling under the mylo-hyoid muscles. Deep incisions in the submaxillary region, through to the oral mucosa, made by E. F. Ingals and myself, found no pus. This subsequently pointed in the prelaryngeal region.

In the case which I present tonight the erysipelatous swelling of the laryngeal interior was either merely a part of the widespread inflammatory oedema surrounding the deep-seated abscess in the neck, or the abscess was part of a phlegmonous erysipelas of the larynx. The lymphchannels of the upper part of the larynx

pass through the thyro-hyoid membrane and pus forming in front of this can burrow downward to the prelaryngeal space. This was the probable route of the infection causing the illness in this case. It may also have reached the prelaryngeal gland upon the thyrohyoid membrane by passing through this. The marked swelling of the tongue at the beginning of the disease makes it seem possible that the infection entered through the lingual tonsil, which P. H. Gerber regards as the site of invasion in most of the erysipelatous processes in the larynx.

The mildness of the symptoms shown by the patient is remarkable. The usual severe chill, high fever and prostration due to deep seated phlegmonous processes was absent. The course of the laryngeal affection also was unusually slow, as ordinarily tracheotomy is needed within one or two days after the beginning of erysipelatous oedema of the larynx.

Oedema of the larynx may readily be caused by inflammations in its neighborhood. I have seen translucent swelling of one ary epiglottic fold caused by therapeutic blistering of the skin of the side of the neck. In another instance it was due to an abscess of the carotid glands and subsided as soon as this was opened.

The spasmodic retraction or depression of the epiglottis mentioned in the history was remarkable and seemed to me to have some part in creating the dyspnoea. I have seen the same position of the epiglottis in the form of a neurosis due to chronic nicotine poisoning. I have also seen it accompany acute laryngitis and disappear with it. The retraction seems to me due to reflex spasm of the thyro-epiglottic and arytaeno-epiglottic muscles which pull down the epiglottis, cause it to fold in the middle and lie against the posterior pharyngeal wall. The depression may also be aided by spasm of the stylo laryngeus and the thyrohyoideus lifting the larynx toward the hyoid bone. In the tobacco case this position caused constant dyspnea which alarmed the patient greatly and left him merely a slit in the folded epiglottis to breathe through.

The adduction of the cords in the patient shown this evening proved to be due to reflex spasm or the adductors and not to posticus paralysis as I had at first supposed it to be, and it and the depression of the epiglottis improved as the laryngeal inflammation grew less. While the swelling was at its height it was impossible to exclude perichondritis of the thyroid or cricoid cartilages from the diagnosis or to be sure that the abscess was not caused by suppuration due to their necrosis.

John Edwin Rhodes,  
Official Reporter.

The Kendall County Medical Society met Tuesday, May 6th, at 10:30 A. M., President J. A. Freeman, in the chair.

This being the first regular meeting of the society it was held in the parlors of Hotel Nading in Yorkville. Minutes of last meeting were read and adopted. Reports of committees received. Committee on fee bill reported, which was then taken up and revised by all the members present and ordered printed. Also



a motion made and carried that a schedule of prices be sent to every physician in Kendall county for his endorsement, after which if satisfactory to all, the fee bill to go into effect as adopted July 1, 1902.

A very pleasant and profitable time was spent discussing the subject of fees and it was fully agreed to by all members present that the fee bill as adopted by this society shall be lived up to. We regret that there was not present more members of the society, but some of the members present vouched for the acceptance of the fee bill by those who were unable to be present.

F. R. Frazier, of Yorkville, made application for membership, which was referred to the board of censors, which report being favorable the doctor was received into the membership.

Motion by Wm. M. Hanna that fee bill be published in county papers as endorsed by the members of the Kendall County Medical Society, carried.

R. A. McClelland was nominated as delegate to the State Medical Society; Wm. M. Hanna as alternate. No other business, meeting adjourned.

R. A. McClelland,  
Official Reporter.

The Livingston County Medical Society held its third semi-annual meeting in Pontiac, May 1, with twenty-two members present. F. H. Crocker, of Weston; J. D. Scouller, of Pontiac; H. C. Sawyer, of Cornell; James Mitchell, of Pontiac; E. E. McCoy, of Flanagan, and F. H. Presler, of Cullom, were admitted to membership. A new constitution and by-laws, to conform to the proposed constitution of the State Society, was adopted, and a fee bill for the county was also adopted and ordered printed.

The following officers were elected: Newton M. Otis, of Fairbury, president; T. W. Jones, of Cornell, vice-president; John Ross, secretary and treasurer.

The subject under discussion was Typhoid Fever. Papers were read as follows:

Etiology and Pathology, O. A. Coss, Saunemin. Symptoms and Diagnosis, G. F. Carson, Chatsworth. Prophylaxis and Treatment, H. E. Johnson, Fairbury. Complications and Sequelae, E. H. Fitzpatrick, Pontiac.

All members joined in a hearty discussion of these subjects. The subject of treatment and diet, especially of milk diet, created a very warm discussion.

V. M. Daly was elected the delegate from this Society to the meeting of the State Society at Quincy, with A. B. Middleton as alternate.

A supper was served at the Hanes Hotel by the Pontiac physicians to the visitors.

At the evening session J. J. Pearson, the retiring president, delivered an eloquent address. The newly elected president, N. M. Otis, delivered an address outlining the work for the coming year and recounting the progress made by the Society during the past year.

Hon. C. C. Strawn, a noted criminal lawyer, was present and responded to an invitation to address the Society. He compared the legal and medical professions and showed how

the medical profession secured advantages by organization and concerted action which were impossible in his profession, which had no organization in this county. He complimented the Society on its organization and asked assistance from its members to secure a similar society for his profession.

John Ross,  
Official Reporter.

The La Salle County Medical Society met in annual meeting April 29.

In the absence of the president and vice-president, P. M. Burke of La Salle, was chosen to preside.

The following program was then presented. Still Birth and Uterine Inertia—L. Thompson, Utica, Ill.

Diseases of the Eye—J. R. Hoffman, Chicago, Asthma—E. W. Weis, Ottawa.

Treatment of Diseases of the Heart.—A. M. Shaw, Ottawa.

Acute Edematous Laryngitis with report of case.—E. P. Cook, Jr., Mendota.

Individuality an Important Factor in the Practice of Medicine.—W. S. Starrett, Marseilles.

The Treatment of Pneumonia.—W. G. Putney, Serena.

What Shall be the Attitude of the Medical Profession Toward the Secular Press.—J. W. Pettit, Ottawa.

The papers were heartily discussed by all members present. Dr. Pettit's paper evoked a lively discussion, every point was gone over and explained in detail and the sentiments expressed therein were endorsed unanimously by the society.

The following resolution was introduced and on motion, adopted.

Whereas, certain persons are practicing medicine in this county contrary to law, therefore.

Resolved, That the La Salle County Medical Society respectfully request the prosecuting attorney of this county to vigorously prosecute all offenders and we hereby pledge ourselves, individually and collectively to assist him in the discharge of his duty if he shall require our assistance.

The nominating committee presented the following list of officers for the ensuing year: President, E. P. Cook, Jr., Mendota; Vice-President, W. S. Starrett, Marseilles; Secretary, W. A. Pike, Ottawa.

Meeting adjourned.

W. A. Pike,  
Official Reporter.

The Medical and Surgical Society of Western Illinois met at Whitehall, Friday, May 2d, with members Carl E. Black, J. S. Williams, A. A. Barnett, C. R. Thomas, H. W. Smith, W. L. Kincaid, F. A. Russell, J. A. Cravens, J. W. Adams, H. W. Chapman, J. W. Redwine and H. A. Chapin, present.

Called to order at 11:30 A. M. Officers for ensuing year elected as follows: H. W. Chapman, Whitehall, president; J. A. Cravens, Wrightsville, 1st vice-president; A. A. Barnett, Jerseyville, 2d vice-president; H. A. Chapin,

Whitehall, secretary and treasurer. Carl E. Black, J. W. Adams, J. S. Williams, board of censors. H. W. Chapman, delegate to State Society; H. A. Chapin, alternate to State Society.

A. A. Barnett, of Jerseyville, then read a most interesting report of a case of **Diphtheria followed by Embolism and Gangrene of Right Leg** of a boy 11 years old—amputation by nature except removal of bone, which was done at Baptist Sanitarium in St. Louis; recovery of patient; discussion by all present followed.

Dr. Adams then read a paper on the **Treatment of Pneumonia**, with review of recent literature upon subject. Paper was discussed at some length by all members present, which proved very interesting and instructive.

The following resolution was adopted:

Resolved, That, when in the process of nature a man is removed from his sphere of activity and usefulness by the hand of death; it remains for his companions and friends of former years, to cast the mantle of charity and forgetfulness over his imperfections if he possessed any, to cherish the memory of his virtues and laudable ambitions, and to express their heartfelt sympathy for those upon whom the bereavement most heavily falls.

Resolved, That in the death of Dr. C. Du Hadway, of Jerseyville, Ill., and Dr. A. C. Corr, of Carlinville, Ill., the members of this Society feel that they have met with a personal loss.

Resolved, That these resolutions be spread upon the minutes, that a copy be presented to each of the families of our late colleagues, and also be published in the Illinois Medical Journal.

H. W. Chapman,

H. A. Chapin,

J. W. Redwine,

Committee.

The meeting then adjourned to meet in Jerseyville, Friday, August 1, 1902.

H. A. Chapin,

Official Reporter.

The **Pike County Medical Society** met in regular session at the office of H. T. Duffield, in Pittsfield, April 24, 1902.

Members present: H. T. Duffield, B. B. Dunn, L. J. Harvey, R. H. Main, C. E. Beavers, F. M. Crane, W. E. Shastid and Geo. A. Humpert.

Minutes of last meeting were read, corrected and approved.

J. G. McKinney of Barry, and Chas. Jones Gose of Kinderhook, were elected to membership.

The annual reports of the treasurer and secretary were read and approved.

The following officers were elected: President, H. T. Duffield of Pittsfield; Vice-President, F. Marion Crane of Pittsfield; Secretary and Treasurer, R. H. Main of Barry.

F. Marion Crane read a paper on **Hydrocephalus with report of a case** which was highly appreciated by those present. He reported a case of Hydrocephalus which recovered under treatment by iodide of potassium and he suggested its use in those cases.

C. E. Beavers presented some clinical notes on **Some of the peculiar manifestations of Hysteria** which were very interesting. He reported four cases in which the manifestations differed widely simulating, (a.) tubercular peritonitis with well marked fever. (b.) Nephritic colic with complete suppression of the urine for several days, etc.

The subject of Hysteria was discussed thoroughly and several interesting cases reported.

W. E. Shastid presented a case of traumatism of the eye in which the cornea had been penetrated producing hernia of the iris. The portion of the iris protruding had been removed by excision. The pupil dilated by atropia and although there was considerable iritis, the patient was improving nicely.

The meeting adjourned.

R. H. Main,

Official Reporter.

Dr. Virgil Beavers, of Beverly, Adams County, has removed to Hutchinson, Kan.

Dr. L. S. Lacy, of Pleasant Hill, Pike County, has removed to Time, Pike County.

The **Jo Daviess County Medical Society** celebrated its second anniversary on April 24, 1902. The meeting was called to order by the president at 11 a. m. in the I. O. O. F. hall, Elizabeth, and the following members present: Stafford, Godfrey, Gunn, Egan, Smith, I. C., Hutton, Eade, Smith D. G., Keller, Phillips, Fowler, Czibulka, Kreider, Wright.

After approving of the minutes of previous meeting. The continuance of the library committee and the report of the auditing committee which proved the society's sound financial standing.

The president in his annual address, suggested that steps be taken by the society to effect an understanding with the board of supervisors of the county whereby the various doctors who render services to such parties as are not able to pay for said services may be paid in full and no reductions made on said bills. A committee of three was named to meet the county board and adjust rates if possible.

At this hour Drs. Hutton and Smith invited the society to a dinner prepared at the Commercial hotel for this occasion, to which all did ample justice.

At 2 p. m. the society reconvened and the annual election followed. President, H. T. Godfrey of Galena; Vice-President, G. E. Miller, Hanover; Secretary, D. G. Smith, Elizabeth; Treasurer, T. J. Stafford, Stockton; Censors, A. C. Phillips, T. M. Eade, I. C. Smith; Delegates to State Society, A. C. Czibulka, J. C. Egan alternate.

The name of Dr. Allen Staples of Dubuque, Iowa, was proposed for membership to be acted on at the next meeting.

The subject of fee bill was introduced and a committee of three appointed to draft one and submit to the society for approval.

A. C. Phillips of Apple River, then read the paper of the day. Subject: **"Bacteria and Serum Therapy from a Practitioners Standpoint."** This was an elegant paper and showed that the doctor had given the subject considerable time



and pointed out the necessity of the general practitioner acquainting himself with the subject.

Dr. Eade very ably opened the discussion on **Bronchitis** which was indulged in by all present. After accepting an invitation to meet in Galena, July 31, the society adjourned feeling pleased with the beginning of another year of society work.

D. G. Smith,  
Official Reporter.

The McLean County Medical Society held a special meeting may 15th, to attend the funeral of their fellow, Dr. John L. White, who has twice been honored as president of the society and to adopt the following resolutions:—

Whereas, the hand of death has taken from among us Dr. John L. White, much loved and respected member of our society; and,

Whereas, Dr. White has been for over 30 years identified in a marked degree with the affairs of this society and of this community; therefore, be it

Resolved, That in his person we saw a rare combination of physical comeliness and mental excellence; that he was a man whose honor was unimpeachable, who despised sham and pretense, choosing to be rated at less rather than above his real value; that in his intercourse with his professional brethren he was the soul of courtesy, consideration and kindness; that while we mourn his loss, the somber background of death brings into brighter relief the picture of a well rounded life, full of usefulness in act and example, worthy of our earnest emulation.

Resolved, That we tender to his bereaved family our heartiest sympathy in their great affliction.

Resolved, That a copy of these resolutions be presented to Mrs. White and daughters and that another be spread upon the records of this society.

William Hill,  
W. E. Guthrie,  
F. C. Vandervort,  
Committee,

There was quite a representative gathering of the members of the medical society from all over the county, as well as an almost entire attendance of the members in this city. No recent event ever brought out so large a crowd of physicians as the funeral of Dr. White. After the action on the resolutions the physicians marched in a body to the home of Dr. White to attend the rites.

The society invited all physicians of the community irrespective of creed to participate with them and the invitation was accepted and hence a large body of physicians were in attendance. The following editorial from the Daily Bulletin is so appropriate and seems to cover the ground so well, I can not do better than to adopt it as ours.

"The death of Dr. J. L. White brings sorrow to many hearts and removes from Bloomington a familiar and loved and respected figure. Dr. White was essentially a big man. A remarkably handsome man of splendid physical proportions, finely chiseled features and a never failing cheery sunny smile, he was as big and

broad mentally as physically and above all had a big heart which throbbed with kindly impulses for friends and neighbors. Such a man could not fail to be a prominent and influential character in the community where he had cast his lot and lived out a well rounded life. He was thoroughly conscientious and utterly fearless in voicing his convictions and his very honesty more than once cost him the chance of political preferment. While his public life was an open book, and his character above suspicion, the closest friends and neighbors who knew him best were those who loved him most and will mourn him long after the last outward tribute of sorrow and respect has been paid. His home life was ideal and while he had fairly lived the allotted time his heart had never grown old and in his last days he was never so happy as when dispensing hospitality to, and enjoying social intercourse with younger people whose lives he had watched from childhood. Despite his silvery locks nobody looked upon Dr. White as an old man and his going forth seems as untimely as it is sad."

F. C. Vandervort,  
Official Reporter.

The Saint Clair County Medical Society held its regular meeting and annual election at Priester's Park March 6, 1902.

In the absence of President Kohl, the recording secretary called the meeting to order and A. J. McGaffigan was elected president pro tempore. Members present were: A. Hansing, corresponding secretary; Rayhill, Grimes, Gunn, State, Twitchell, Starkel, Wiggins, Lillie, H. and H. G. Hertel, Fairbrother, Little, Raab and B. H. Portuondo, recording secretary, and W. E. Wiatt and A. Reis visitors. Minutes of last meeting were read and approved. Report of treasurer showed a balance of \$27.50 in the treasury. Report approved. Bill of Priester \$3.10 for refreshments at our last meeting was presented, and on motion allowed.

The chairman appointed Rayhill, H. Hertel, A. Hansing a committee to nominate officers for the ensuing year. The committee reported as follows: For president, H. C. Fairbrother; for vice-president, A. B. Gunn; corresponding secretary, C. W. Lillie; treasurer, A. Hansing; recording secretary being a permanent officer, B. H. Portuondo continues in that office. On motion the report was accepted, the committee discharged, the rules suspended and the several officers elected by acclamation.

Chairman McGaffigan appointed Hansing and Grimes a committee to escort the new president to the chair.

President Fairbrother delivered a brief address in which he urged the members to attend the meetings and participate in the proceedings. He looks upon the county society as a unit in the organization of the State and National Associations, and as the chief agent or element in the upbuilding of the profession. Without these societies the profession would deteriorate and decay. They tend to elevate and maintain the dignity and high moral and intellectual status of the members. The medical society stands for the dignity and elevation of the science of medicine as other crafts stand for their eleva-



tion and prosperity. All crafts have their unions and stand together better than does the medical profession. How much better would it be if we also had a "more perfect union." What might we not attain if we all stood together?

The death of John Stack an excorresponding secretary of the society was reported and on motion of J. E. State, a committee of three, J. E. State, H. G. Hertel and C. W. Lillie was appointed to draft a suitable memorial. The committee reported the following tribute, which, on motion, was adopted:

The St. Clair County Medical Society deeply deplores the death of John Stack, a member of this society. We attest to his skill in his profession and to his genial character as a man. We realize that the profession has suffered a great loss by his premature death, the state has lost a useful citizen, the community a valued and active member.

We extend our profound sympathy to his mother, his only near relative, in her sad bereavement. We devote a page of our record to the perpetuation of his memory.

Starkel offered the following:

"Resolved, That it is the sense of this society that all our members should become members of the State Society." Motion by Lillie that the resolution be adopted. Carried.

Dr. Wiggins made some observations on the various "Forms of Sutures in Enterorrhaphy" and demonstrated the use of various instruments employed in this work and illustrated the manner of making the most approved suture and especially the means by which all the knots may be placed within the lumen of the gut. He also showed the manner of using the Murphy button for intestinal anastomosis. Discussion by Starkel: I deem this paper one of the most valuable features of the meeting. By the very excellent demonstration the members have learned something of the actual work. I have made this operation on dogs, but it is now made still more clear to me. I think the society owes Dr. Wiggins a vote of thanks for his demonstration.

Wiggins closing: When we recall the enormous loss of life which formerly attended wounds of the abdominal viscera and the achievements of modern surgery, we may well express surprise. The death rate from this cause in the Crimea and our own civil war was about 98 per cent. now the figures are almost reversed. And I believe that some of the fatalities of recent years have been due to faulty sutures. I recall a case on which I operated in 1892, making anastomosis with Lembert sutures. The patient recovered, but died last year from adhesions and inflammatory products due to the Lembert suture. On motion the society adjourned.

B. H. Portuondo.

Official Reporter.

The Sangamon County Medical Society met in regular session Monday evening, April 14th, at the court house, L. C. Taylor, president in the chair. The minutes of the March meeting were read and approved. Motion was made and carried that janitor be allowed \$1.00 per meeting. Bills of Phillips Bros., State Register and secretary ordered paid.

Dr. R. D. Berry read a paper on Alkaloidal Medication, a synopsis of which follows:

Since the time of Adam, man has been seeking remedies in the animal, vegetable and mineral kingdoms for the alleviation or cure of disease. The earliest records tell us that the ancients gave the brews of snails, snakes, and lizards. After many centuries a material advance was made and infusions of some plants were given which had little therapeutic value. Later on a few drugs of definite action were found and used, calomel and ipecac being among them. An unknown doctor of the period expressed the central—the eliminating—idea in the following couplet:

"I pukes, I purges, then I sweats 'em,  
Then if they die, why then I lets 'em."

Treatment based on this idea of elimination was quite an advance and from this time on therapeutics made rapid strides, being put on a more firm basis by histology and pathology, chemistry and pharmacy.

Modern physicians have dropped polypharmacy and now give single remedies, or two or three at most. There is also a demand for pure medicines in a small bulk and herein Alkaloidal Medication shows in its best light. The idea, which is the giving of the active principles in granule form on small frequent doses, pushed to effect was originated by Burggrave of Belgium, some 30 years ago, and is therefore not a new idea. Dosimetry is not homeopathy but rather scientific medication, for its dosage to effect; for example it is desired to produce sleep by the administration of hyosine; a granule is given every five minutes until sleep ensues. It may take two granules in one case and eight in the second case, but each receives the dosage that is required to produce the desired effect.

Dr. Berry continued at considerable length giving in detail the indications for the use of many of the alkaloids together with the dosage and method of administering them.

In closing he said that he contended that no matter where the remedy comes from if it cures in a certain disease that remedy should be used. Some physicians are afraid of the alkaloids, but used in small doses to effect there is no danger. By using the granules you can have your medicines with you, to use at once, and they are quick, potent and certain forces. The question may be asked: can a physician practice medicine successfully with the alkaloids alone? Perhaps he might, but I would not advise it for the reason that following along one line of practice has a tendency to make a man narrow: he is liable to get into a rut and he will not grow into the broad, liberal minded physician he should be.

Under report of cases and presentation of pathological specimens the following were reported:

G. N. Kreider reported the case of a farmer admitted to the hospital and operated upon. Symptoms were those of appendicitis. When the incision was made the bowels were found coated with plastic lymph, pus and gall stones were found. No post mortem could be had. Stones were covered with fecal matter. Seeds from

bowels also found. He also presented a uterus showing fibroid growths, interstitial, submucous and sub-serous. Also two specimens of amputation of the breast, together with the glands, one being tubercular, the other cancerous.

A. L. Brittin reported a case of septicemia. In unloading lumber patient thought he had run a splinter into palm of hand and had attempted to remove same with pocket knife. Two days later had a palmar abscess with whole limb much swollen. Six days from injury he complained of rheumatism of opposite elbow. He continued to grow worse and died on the 17th day after injury. No external evidence of the injury could be found.

W. O. Langdon reported a somewhat unusual case of puerperal eclampsia, that of a woman in her 7th pregnancy who had never had any trouble previously. To the 8th month she had apparently been well and repeated examinations of the urine were negative until one week from the attack. Two days before the attack there was headache and slight albuminuria; in 24 hours urine was loaded with albumin and it was decided to dilate and deliver, this was after the first convulsion. There was a slight convulsion during the delivery but none since and both mother and child are doing well.

L. C. Taylor presented the heart and pericardium of a recently deceased patient, that of a man apparently 50 years old who entered the hospital in a dying condition. Pulse very weak and rapid. Dyspnea was intense, breathing stertorous, with much coughing. On examination extensive dullness was found in region of heart and pericardium. Death followed in a short time. Post mortem showed pericardium dilated enormously and containing nearly half a gallon of fluid. There was also a very large amount of fibrous exudate. Dr. A. P. Condon demonstrated the case to be tuberculosis of the heart. There was no involvement of the lung detected.

The committee appointed at the March meeting to revise the fee bill made an extensive report.

On motion the fee bill was taken up, considered, amended and adopted by sections, after which it was adopted as a whole.

On motion \$5.00 was ordered paid to the stenographer who made the temporary copies of the fee bill. Each member present having been supplied with a copy.

The committee were instructed to secure the signatures of as many non-members of the society in the city and county as possible, and to have them printed on the fee bill together with the names of all members of the society.

It was also voted to have the fee bill printed on a card and also in book form. Each member to have a copy of each free. The secretary was instructed to furnish non-members with a copy on payment of fifty cents.

Meeting adjourned.

F. B. Fisher,  
Official Reporter.

The Macoupin County Medical Society met in the Masonic hall at 10:30 a. m., April 22.

President J. Roscoe Ash called the meeting to order. The following members answered to their names: J. Roscoe Ash, Brighton; N. A.

Crouch, Chesterfield; W. B. Dalton, Scottville; T. A. Hornie, Brighton; A. G. Kinkead, Greenfield; E. A. Bleuler, J. P. Denby, J. M. Barcus, J. S. Collins, J. P. and J. Palmer Matthews, J. C. Fischer, of Carlinville.

A motion was made to create honorary members of the following named gentlemen who have moved out of the county, viz.: T. N. Burwash, Champaign; Elias Davis, Peoria; J. H. Gilson, Raymond; W. S. Kinkead, Roodhouse; J. A. Mansfield, Illiopolis; H. W. Smith, Roodhouse; C. A. Wuin, Mountain Park, Oklahoma.

Minutes of preceding meeting were read and approved.

Treasurer reported a depleted treasury and an assessment being declared of 50 cents a member. A balance was collected of \$3.05 above expenses.

Dr. Matthews then read an address on our late brother, A. C. Carr, which was, on motion, \$100.00 on the minutes, viz.:

"Dr. Carr was my friend and this means more than the usual term for it tells the story of more than a quarter of a century. Beginning as a student and extending on through the ups and downs of a busy professional life; one long unbroken chain of kindly, sympathetic, good fellowship. His qualities of mind and heart endeared him as a brother. To know him as I did was to always know where to find him true as steel.

"Of his professional attainments I will not speak. I need not speak of them to this society. That part of his life is an open book known and read by all of you.

"Ever faithful to his chosen profession, he threw all his heart into the creation of the Macoupin County Medical Society, and his never failing influence into its welfare. He was truly its nestor.

"His work for the good of the society and the medical profession is fully shown by the many able papers and publications from his pen. His qualities of head and heart, his many positions of trust and honor speak in loudest terms of the high esteem in which he was held by this society and profession.

"Living, he acted well his part: Dead he admonished us who are left behind that we worthily imitate him. Beloved brother rest in peace."

Signed J. P. Matthews, M. D.

The nominating committee reported Carlinville as the next place of meeting. Program; Essayists.

F. C. Barto, Plainview.

E. A. Bleuler, Carlinville.

J. P. Denby, Carlinville.

For President, H. W. Gobble, Greenfield; Vice-president, W. A. Crouch, Chesterfield.

On motion the secretary cast the ballot of the society for the gentlemen named and they were declared elected for the ensuing year.

The committee also recommended that the society instruct the secretary to have some noted and competent man to address the society on some scientific and practical subject pertaining to medicine.

Motion carried to empower the secretary to appoint as delegates all to the State society, all who may attend the May meeting in Quincy.



Reports of Cases. Dr. Matthews reported a case of **profuse haemorrhage from the lung of a consumptive patient.**

He asked how many would give Ergot under this emergency of haemorrhage of lungs?

Atropia was given to dilate the peripheral capillaries and remove the peripheral resistance and draw the blood away from the internal organs.

Then a hypodermoclysis of normal salt solution was given with most excellent results.

It was the sense of the society that the shock should be overcome by free use of stimulants as glonoin, strychnine and spirits frumenti.

An essay was read by Dr. Dalton of Scottville, entitled: "**Antiseptic Treatment of Typhoid Fever.**"

Synopsis—Prophylaxis consists in personal cleanliness of patient and attendants. The physician should prevent auto-infection and re-infection with germs of bacillus typhosus and pyogenes alba and oris, causing mixed infection.

Infection is swallowed and should be destroyed as quick as possible.

When first symptoms arise, bacilli have penetrated too far into the tissues and are far beyond purgation.

Intestinal infection—Mixed infection should be prevented by disinfection of the alimentary canal.

Purgation and disinfection are the indications.

Antisepsis should begin with the toilet of the mouth. Mouth should be washed every four hours with listerine or chlorate of potash.

Best intestinal antiseptics are carbonate of guaiacol and volatile oils. Turpentine gtts. II, Eucalyptus, gtts. I, Thymol gr.  $\frac{1}{4}$ . These given in emulsion will be followed by abatement of high temperature and general perversion of secretions.

Purgation every four hours keeps down organisms of infection. If ulceration has taken place purgation is contra indicated.

Irrigate the tissues and blood with frequent draughts of pure water.

Support strength with digestible, non-irritating food. Milk meets all requirements.

If curds form dilute the milk with water or pre-digest it. Eggs, soft boiled or poached. Carbonated water will stop vomiting.

Insomnia, sub-sultus tendinum and jactitation call for bromides. Maniacal delirium calls for opium, carbonate of zinc and bismuth sub-nitrate. Haemorrhages are not well endured and are very debilitating; check bowels for 48 hours with opium and acetate of lead. Elevation of temperature calls for sponging with water and dilute alcohol. Fan the patient moist with water at temperature of 60 degrees.

Dr. Dalton's paper was on motion, accepted as a contribution and discussed by the members.

The valedictory address of Roscoe Ash, president of the society, was entitled: "**National Medical Legislation.**" It was moved that it be accepted as a contribution to the society and a copy be sent to the Illinois State Medical Journal for publication.

J. Palmer Matthews, A. M., M. D.

Secretary Macoupin County Medical Society.

The Chicago Medico-Legal and the Chicago Medical Society held a joint meeting May 14, 1902, with N. S. Davis, Jr., president Chicago Medico-Legal Society, in the chair.

E. Fletcher Ingals read **A Bill to Establish a State Board of Medical Examiners.**

George W. Webster, in opening the discussion, said that it was very important that we should have in the United States greater uniformity in the courses of medical instruction. It would be impossible to have a national examining board which could issue licenses that would be recognized anywhere in the United States. This was contrary to the Constitution of the United States. Therefore, reciprocity was the only way in which this could be carried out and licenses recognized in the various states in the Union. Reciprocity must be based on, first, uniformity of preliminary entrance requirements; second, uniformity of length and character of the medical course; third, uniformity in regard to the character of the examinations.

He said there was one point which might be considered, that is, we had a good deal of trouble in Illinois at the present time with men living in other states and advertising as Dr. So and So, and having the same name as those living in the state and practicing under their names. He thought there ought to be some way of reaching such men, but there was no provision made in this act for reaching that class of practitioners.

John M. Dodson said there could be no question as to the great desirability of having a state medical examining board in Illinois independent of the State Board of Health. The State Board of Health had enough to do to look after the sanitary matters of the state. He said about seven-eighths of the time of the Board of Health was spent in issuing licenses to practitioners, and it had very little or no time to devote to the health matters of the state. This was no reflection on the board, as it had not time to give to sanitary matters. The medical examining board should be entirely distinct and separate from the State Board of Health. He would be perfectly willing to trust the appointment of this board to any governor of the state we were likely to have, because the majority of members of such board would be appointed from the ranks of the regular profession. He favored the appointment of a board by the governor, which shall consist of seven regularly licensed competent practitioners of medicine.

Harold N. Moyer said there was too much contained in the bill. He would not put anything in a bill which was worthless. The provisions relating to definition of what constitutes unprofessional conduct, and the revocation of licenses were of very little use in such a bill. They interfered with the rights and liberties of individuals. He thought it would be better to abolish that part of the bill relating to the definition of the practice of medicine. This was freely discussed in the old committees for years. The act would be much stronger if the definition were left out. A registration board was very desirable. He fav-



ored a medical examining board. He thought the bill was complicated and it would be difficult to put it through at Springfield in its present form. If the committee directed its energies to simply establishing a medical examining board and stopped there at the forthcoming session, he thought it would do well, rather than to take a bill as complete as this was in all its parts, and attempt to pass it, because it would admit of such wide discussion. He believed the enactment of the bill in its present form would take twenty years. Under no circumstances could it be passed at any one session of the legislature.

D. W. Graham said that the bill was entirely too complicated, and contained too many detailed provisions. He thought the definition of the practice of medicine was one of the best things in the bill. He disagreed with Dr. Moyer in that respect. He thought this was drawn by Judge Shope for the old bill, and was in the present bill word for word. Some of the sections of the bill were not harmonious. For instance, "Candidates who desire to practice medicine and surgery in all their branches" shall do so and so. He thought this was a peculiar expression. A man might want to practice only one branch of medicine, as Dr. Ingals did, or somebody else did. He maintained it was wholly unnecessary to specify these things, and in all such bills he would leave out medicine and surgery, especially when used in conjunction with the other provision, "Candidates who desire to practice midwifery shall file with the secretary of the board a regular application on a form prescribed by the board," etc. He said there could be a man midwife or a woman midwife, or both. He said he or some other physician might want to practice midwifery along with surgery and medicine. He understood that many practitioners did this. In all the provisions there should be simply mentioned the practice of medicine, and then define what it is, leaving out medicine and surgery and all their branches. This was too specific and attempting to do something that one could not do under the law. A statement should be put in referring to midwives, and defining what a midwife is. As to the title it undertook too much or not enough. It did not include everything, yet it attempts to be specific and include practically everything. He thought if we could have a short bill providing simply for a board of medical examiners, it was possible to have it enacted.

A. M. Corwin said that by receiving criticisms of the bill and sifting all of its provisions, a conclusion might be arrived at as to what should and what should not be included in the bill. Then, we might have something which would be creditable and practicable. He thought before the bill was brought before the legislature the profession should have a medical organization back of the gentlemen who are to present the bill to certain legislators. Efforts should be made to have thousands of letters written to our state representatives, so as to bring as much pressure as possible to bear upon the enactment of the bill.

Alexander Hugh Ferguson asked whether the profession of the State of Illinois had ever

asked the legislature for a medical bill which empowered the profession as such to have a council to deal with all of these details. This was the way it was in every province in the Dominion of Canada, and it worked admirably. This council may be composed of representatives from the medical colleges, representatives from the universities, and representatives from the medical profession, including the isms, because these could not be overcome. He thought such a council would elevate the organization of the medical profession above politics, would always keep it out of politics, and it would prevent the Governor of the State from making any appointments in accordance with party politics.

Carl E. Black said the committee was more anxious to have criticisms than commendation. The committee was anxious to find out what the profession of Illinois would like in such an act, what the regulation of the practice of medicine should be. In answer to Dr. Ferguson's question, he said the State of Alabama was the only state, so far as he knew, which had the regulation of the practice of medicine with in the hands of the regular medical profession. As to pathies, the committee had recognized in some way homeopaths and eclectics, but it had tried to do this in the bill without naming them. The committee had tried not to recognize any pathies in medicine, at the same time it had tried to provide for those that do exist.

E. F. Ingals, in closing the discussion, said, in reply to Dr. Webster, that if there was no provision in the act for reaching those who practice in this state as representatives of some one who advertised in another state, it would be attended to.

He thought the suggestion of Dr. Dodson that the board of medical examiners be appointed by the governor without any nominations, was a good one. This point the committee would discuss.

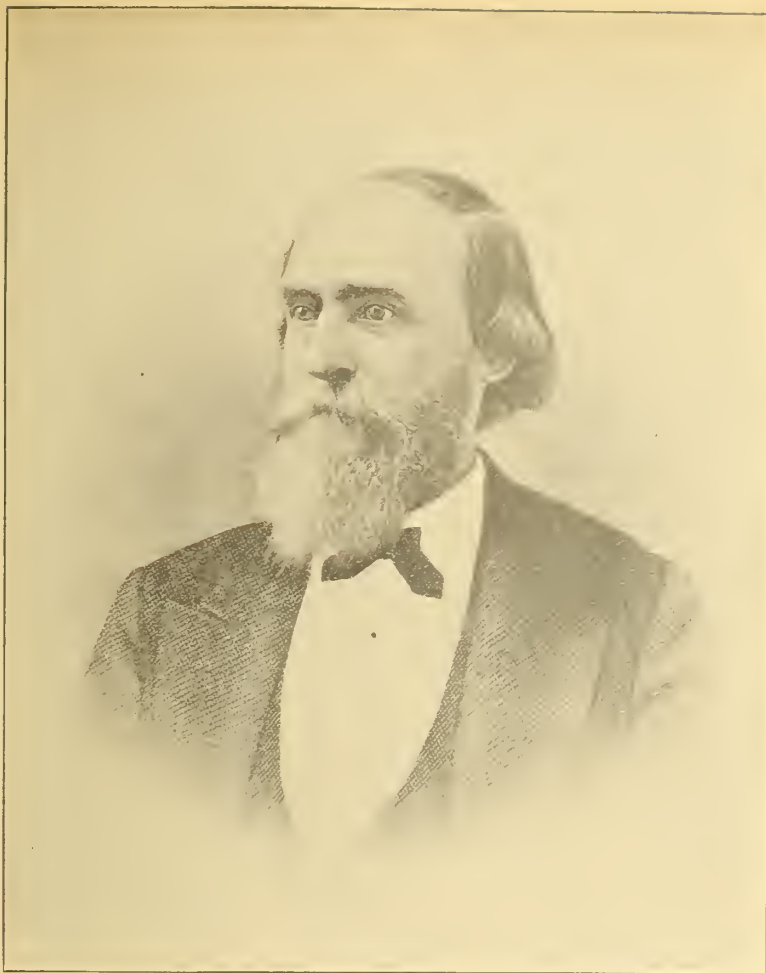
As to the phraseology of the bill, it was very largely that used in the present act, and based largely on court decisions.

As to the length of the bill, it was about one-third that of the average medical bills that have been passed in various states. He did not think the length of it was an important matter.

With reference to the definition of unprofessional conduct, there was room for discussion as to whether this should be put in the bill or not. If the profession would combine as it did two years ago, or even better than it did then, he thought the profession could get almost any bill enacted by the legislature that it wanted, if legislators were approached in the right way. Legislators would do what their constituents wanted them to do. Whatever their motives might be, this was what they were there for.

He did not think the bill was complicated when compared with the majority of medical practice acts, and with those the committee examined.

The wording of the bill would eventually be placed in the hands of a lawyer.



JAMES V. Z. BLANEY, PRESIDENT, 1870.

**MAPLEWOOD  
DR. NORBURY'S  
SANATORIUM**

FOR THE TREATMENT OF  
**NERVOUS AND MENTAL DISEASE**  
JACKSONVILLE, ILLINOIS

**CONSULTING STAFF:**

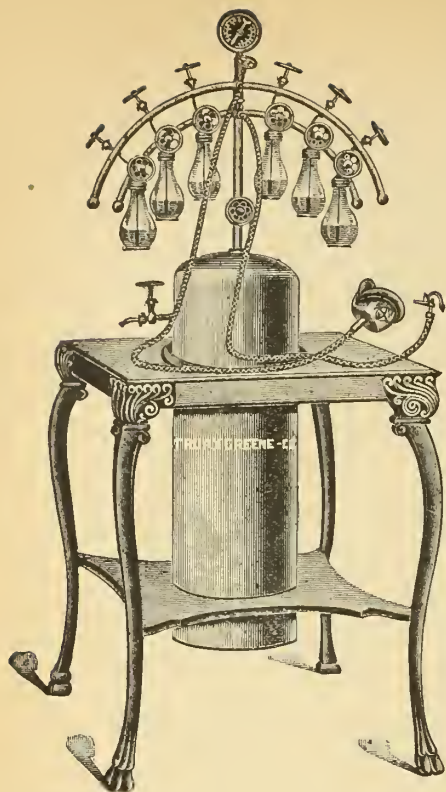
FRANK R. FRY, M. D.,  
St. Louis, Mo.

CHARLES G. CHADDOCK, M. D.,  
St. Louis.

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The Official Organ  
of the  
State Medical Society



Monthly Under Direction  
of the  
Judicial Council.

Printed by

THE ILLINOIS STATE JOURNAL COMPANY.

Entered in the Springfield Postoffice as Second-Class Matter.

Volume LII,  
New Series, Vol. IV. }  
Number 2.

Springfield, Ill., July, 1902.

{ Subscription, \$3 a Year.  
Single Copies, 25 Cents.

FOR SPECIAL FEATURES SEE FIRST EDITORIAL ARTICLE.

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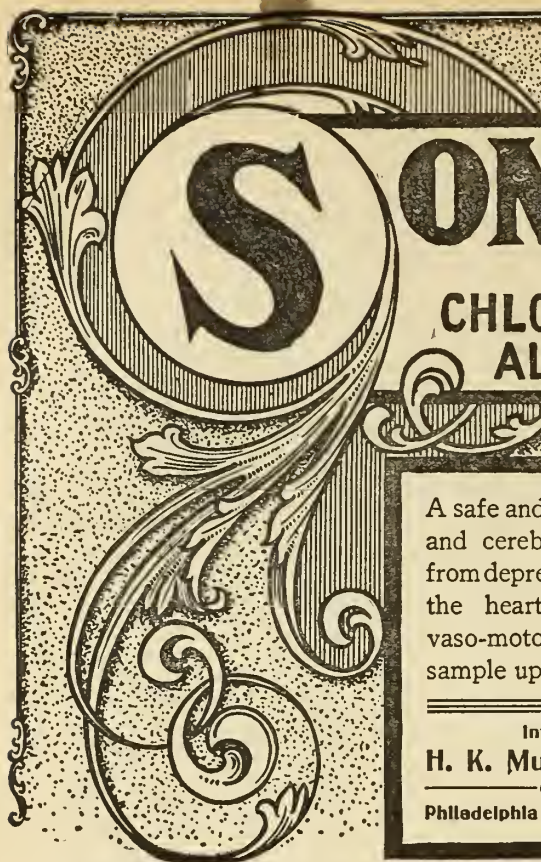
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Springfield, Ill., July, 1902.

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## PERNICIOUS ANEMIAS; THEIR DIAGNOSIS AND TREATMENT.\*

BY GEORGE DOCK, M. D., PROFESSOR OF MEDICINE IN THE UNIVERSITY OF MICH.,  
ANN ARBOR, MICH.

When, in accepting the flattering invitation of the distinguished Chairman of the section in practice of medicine, etc., I cast about for a topic worthy of your consideration, a number of things conspired to make me select pernicious anemia. Among these reasons I may mention in the first place, that this is a widespread condition, and though relatively rare, occurs often enough to make it well for the physician to have his mind turned towards it so that no matter which one of its many aspects it presents he may be prepared for it. Further, several of your members have made most important contributions to our knowledge of the subject, and in thus making us their debtors have laid on us all the obligation of adding what we can to the common fund. Finally, my own interest was early attracted to the subject by some of its first students in this country, such as Pepper, Osler and Musser, and chance has thrown in my way a considerable amount of clinical material.

Of the early history of pernicious anemia, absorbing as it is, I shall say little. The differences of opinion of Addison and his followers on the one side, and Biermer and others on the opposite have not yet been wholly reconciled. In many of the early studies the efforts made to elucidate the subject were verbal rather than material. Such words as "essential," "idiopathic," "primary," were used with a seeming confidence in their potency that later readers can hardly understand. A striking evidence of the early difficulties was the belief that a positive diagnosis was not possible during life. Bristowe, as late as 1888, said, "It

is impossible to lay down any trustworthy distinction between the chlorosis of young girls and pernicious anemia, except such as depend on the age and sex of the patient, and in the effects of treatment." Yet the post mortem features relied upon to settle the diagnosis, such as fatty degeneration and hemorrhages, were by no means capable of satisfying a critical investigator. Notwithstanding the minuteness of the clinical examinations in many early cases there was a very important feature that was imperfectly studied, viz., the blood. Many interesting facts were early learned about the blood, but the importance of stained preparations was discovered comparatively recently. The other details received only irregular and uncertain attention, because, exploited often as pathognomonic features, each in its turn, they often led to disappointment and consequently to neglect. It was hard to realize that in the study of the blood during life we might have anatomical material quite as useful in a diagnostic way, as the much-talked of fatty degeneration of organs. Even now the neglect of a complete study of the blood too often happens, and some otherwise valuable observations have thereby been rendered almost worthless.

The work of a large number of observers since 1880, when Ehrlich described the nucleated red blood corpuscles, more fully than had been done before, leads to the conclusion that the final diagnosis of pernicious anemia depends on the blood examination. Although fatal cases of anemia may not correspond with the blood conditions in pernicious anemia, and the results of autopsy may not permit us to positively class them with other definite diseases, we seem warranted in holding to the statement just made. Two other decided gains have been made besides the recognition of the blood changes. One of these is the knowledge of the excess of iron in the liver cells,

\*Address before the Section on Practice of Medicine, Quincy, May 20, 1902.

discovered by Quinke and made the basis of Hunter's important work. The other is the demonstration by Schauman, of the similarity of the blood in bothrioccephalus anemia to that in pernicious anemia. While neither of these advances is as yet complete, they help us to form a more satisfactory idea of the condition than was possible before. In common with the majority of those who have studied pernicious anemia, I look on this not as a distinct and specific disease, but as a symptom-complex. However, as a matter of convenience I shall often speak of it as a disease. The complex includes a number of features that can be made out by the anamnesis and the ordinary methods of examination, and these features occur in such frequent combinations, and so strongly marked, that a diagnosis can sometimes be made by them alone. But the exact diagnosis, the only useful one very often, and the indispensable one if the case is to be used to advance our knowledge, is based on the condition of the blood. To this I shall return again. From this point of view the term pernicious anemia is as useful as any other that has been suggested, and since it involves neither theory of cause nor unproved anatomic seat, is preferable to any other name hitherto proposed. The addition of Biermer's term "progressive" is unnecessary, and has sometimes been misleading, as Quinke early predicted it would be. The objection urged by some, that the word pernicious should not be used because some cases have recovered, is not very sound, because the exceptions are few and moreover the term is after all only relative. (*"Morbi animi perniciosiores pluresque sunt, quam corporis."* Cicero.) The alternative, favored by some, anemia gravis, might have been conveniently adopted as a technical term, had it been introduced early, but as there are not a few secondary anemias with very different clinical features that fully deserve the epithet gravis, it is now more equivocal than the term in common use.

What are the origins of pernicious anemias? Regarding this question our ideas have undergone considerable change since Biermer attributed them to poverty, the puer-

peral state, unhygienic surroundings, discharges such as diarrhoea, and hemorrhages, and Gusserow about the same time to pregnancy. Cases following hemorrhage and pregnancy seem not only relatively but absolutely rarer than was formerly thought, while poverty and unhygienic surroundings can be positively excluded as factors in a fairly large proportion of cases. Many of my own patients were farmers or village dwellers, whose homes and food material left nothing to be desired. On the other hand, faulty preparation of the food and bad habits of eating could often be discovered. Intestinal parasites are important causes in many parts of the world, and in all cases should be searched for by examination of the stools. Common as pernicious anemia is in my field of observation, intestinal parasites are comparatively rare, and though I have paid special attention to the point I have not found a case in which I could trace any connection. I have been struck by the large proportion of patients with infectious processes in the mouth, such as carious teeth, gingivitis, and pyorrhea alveolaris. Dyspeptic and diarrheal conditions have often been noted early, but in other cases similar symptoms seemed rather to be the results of the anemia. Much valuable work bearing on pernicious anemia can be done in cases of gastro-intestinal disease by careful studies of the blood. Syphilis is an occasional cause of pernicious anemia that should always be borne in mind. Malaria and typhoid fever I have never been able to prove as causes in my cases. But it is unnecessary to enlarge on this phase of the subject. Even with the clearest history of previous disease we are still ignorant of the connection between it and the peculiar changes in the blood. Whether this is a specific poison, as some believe, or a toxic substance that varies in different cases, has yet to be proved.

We are but little better off when we come to discuss the pathology, or as some prefer to call it, the pathologic physiology, of pernicious anemia. We can limit ourselves to the blood and blood-forming organs, because most of the other alterations can be ascribed

to the anemia itself, others to unknown poisons causing or resulting from early or late complications.

In studying anemias it is necessary to recall some facts, obvious but often forgotten, about the blood. This substance, medium and tissue both, constantly changes in the healthy body and constantly remains nearly the same in chemical and histologic constitution. Red corpuscles are ever being worn out and renewed, leucocytes come and go, the plasma gives and takes its organic and inorganic elements. An important feature is that degeneration and regeneration do not show themselves in the healthy blood, though we know they are present. Even a direct loss of a moderate quantity of blood, as we see after menstruation, normal confinement and hemorrhage from small wounds, is replaced without evidences of effort. With larger losses we do see such evidences. Unusual corpuscles, young or unripe cells, normoblasts, appear, as if the demand for mature cells could not be met. The same thing happens also in simple anemias, due to disease, and we also find the same sometimes in pernicious anemias, but in the latter we see other forms megaloblasts, such as rarely occur in benign anemias, even when severe, and in fact do not belong to the products of adult blood formation, though they do to that of the fetus. And not only do we find such cells as belong to the later period of fetal life, when the blood-forming organs are fully developed, but also those belonging to the earliest stages, before there is bone-marrow, and when the capillaries and the liver are the seats of active blood formation. Why this abnormal kind of blood formation should occur in disease is not easy to understand. It might be supposed that it represents the final effort at compensation on the part of an almost paralyzed blood-forming function. On the other hand, it may be due to the kind of irritant in the disease. At all events, clinical evidence indicates that megaloblastic blood is not as useful as normoblastic blood for the post embryonic organism. It is the index of the pernicious change.

In fatal cases, we find, corresponding to the alterations in the blood, not only evi-

dences of abnormal growth in the bone-marrow, a reversion to the late fetal type, but even in the liver. But the changes in the bone-marrow are not uniform. In some bones normal conditions prevail, or there may be hyperplasia of normal adult tissue. Such things help to explain the remittent or prolonged course in some cases. In others there is no attempt at normal regeneration. Is there still another process, one that has been thought to be the chief anatomic basis of pernicious anemia—a perversion of marrow to the megaloblastic type without preceding increased destruction of blood? This question carries the problem of pathogeny farther than one can profitably follow it at this time. I confess to a leaning towards the belief that pernicious anemia is due to excessive and peculiar degeneration of blood-cells, especially in the portal area, with the fetal type of blood formation secondary, perhaps as the result of the incompleteness of the ordinary tissue, as Eichhorst long ago supposed. Those who have not yet read Schauman's fascinating work on "Pernicious Anemia in the Light of the Modern Toxic Hypothesis," (Volkmann's Sammlung, No. 287, 1900) will find the whole matter discussed there in a most suggestive manner. On the other hand, the view of megaloblastic degeneration of the marrow, or megaloblastic new-growth of that tissue, with increased blood destruction due to the presence of many vulnerable cells in the circulating blood, cannot yet be entirely set aside as impossible. It is not enough to find a megaloblastic new-growth in bone-marrow, somewhere, and megaloblasts in the blood. Given such a case we have still to ascertain whether the full picture of pernicious anemia has been present.

Regarding the practical diagnosis of pernicious anemia, it is unnecessary to speak in some detail. It is generally accepted that the diagnosis of an anemia—using the word in a wide sense, cannot be positively made by inspection only, but in pernicious anemia this is sometimes less true than in other anemias and one is often struck at first glance by the marked pallor of skin and mucous membranes, the yellow tint of the skin and the peculiar yellow sub-conjunc-



tival fat; by the slight oedema, the shortness of breath on exertion, the weakness and languor, the flabby muscles with the subcutaneous fat often well preserved. When in addition to these we get a history of palpitation of the heart, of fever, of anorexia, vomiting and diarrhoea, of dizziness, numbness or tingling, the suspicion increases almost to certainty. But often the symptoms are not so marked, the history not so full. Weakness, dyspnoea, dyspeptic symptoms and diarrhoea may be the only complaints in some cases; pain in, and palpitation of the heart in others; general weakness in others; dyspnoea and oedema in others; dull pains in the abdomen and weakness in others. Most of the cases that come to me with any other than the correct diagnosis are called either heart disease or malignant disease. Many have been treated long with digitalis. In none of these cases have I found the simulation of severe valvular disease, as we sometimes see in chlorosis. In not a few cases the diagnosis of leukemia has been made and given to the patient, without any blood examination. Addison's disease is often suspected, on account of the weakness. In one of my cases, with vitiligo and its characteristic pigmented areas, the resemblance was close, but the blood-picture very different. A combination of the two diseases is of course possible. One patient, a candidate for matrimony, complained only of impotence, though the pallor and yellow tint were enough to suggest severe anemia.

Any of the symptoms mentioned indicates a complete examination of the blood. The stomach symptoms may strongly suggest cancer. Examination of that organ may reveal absent HCL, perhaps abnormal fermentation, sometimes a tumor. The combination, in comparison with the total number of cancers of the stomach is doubtless rare. Two well marked cases occurred in my series. Examination of the stools may show fermentation diarrhoeas, catarrhal dysentery, or parasites. There may be a distinct history of syphilis. In all of my syphilitic cases, three, treatment for the specific disease had been badly carried out or neglected. Some cases of chronic malaria, with intense pallor, yellow tint,

dyspnoea, and oedema strongly resemble the external appearance of pernicious anemia, but in several such cases I have seen the blood picture was very different.

As regards the blood in pernicious anemia, the manner of flow is rarely especially suggestive, being usually scanty in my experience, but the drop is more watery, the color darker, though also transparent, than in other anemias of equal corpuscular strength. In the microscopic examination of the fresh drop, a matter we should not neglect, we notice the great variation in size and shape of the red cells—nearly always more marked even with high counts, than in other anemia conditions—and the deeper color of many individual corpuscles. The scarcity of leucocytes and blood-plates, the scanty fibrin, and the tendency of the red cells to form heaps rather than rolls, complete the picture.

The corpuscles should be counted. In a marked case the poverty in red cells is diagnostic, for the alternatives suspected rarely have so marked an oligocythemia. It is instructive to allow observant students, as I have sometimes been able to do in my clinic, to compare two patients outwardly alike, one with cancer with three million red corpuscles and thirty per cent. of hemoglobin, the other with pernicious anemia, with a million and a half reds and forty per cent., or with nine hundred thousand reds and twenty-five per cent. of hemoglobin.

But not all cases have such low counts, and to limit the diagnosis to those with less than one million corpuscles leaves out some of the most important. One may find very characteristic changes with a million and a half, two million, or even more. Quite as important is the determination of the color strength or hemoglobin. Except in rare instances this will be as high as or often higher than the proportion of red corpuscles.

Examination of the specific gravity of the blood and of the cells and serum separately is also of value.

A special count of the leucocytes forms part of the complete examination. The estimation of these cells along with the reds admits too great an error. Capps has emphasized the value of the hematocrit in the study of pernicious anemia, showing,

as it does, the increased volume index of the red corpuscles.

Though this part of the examination, like the general appearance of the patient, suffices to make the diagnosis in many cases, the examination of stained preparations is necessary for the final verdict and essential in the less advanced cases. For this we need well-made spreads. As the staining is for the purpose of bringing out fine details of nucleus and protoplasm we need clear nuclear and protoplasm—rather hemoglobin—dyes, and not such as are necessary for showing cell granules. Hematoxylin and eosin are most satisfactory in general but eosin and basic anilin dyes can also be used. The study of the preparation is best made by a systematic search with a mechanical stage, noting the differential count of the leucocytes, the number and special features of nucleated red cells, the details as to shapes and sizes of red cells, polychromatophilia, basophile granules. The habit of sketching all noteworthy appearances will make much for accuracy and furnish useful records. In the study of the nucleated red cells certain individuals will give rise to difficulties that experience cannot wholly remove. Typical normoblasts and typical megaloblasts are easy to recognize. It so happens that in practice many nucleated red cells do not come under either category. Ehrlich, in describing these cells, was not ignorant of the difficulty, but his remarks in relation to it were not satisfactory. The fact, as he then believed, that there are differences in the fate of the nucleus in the two classes of cells was obviously of little value in a stained and mounted preparation. The other diagnostic feature, that one kind of cell occurred in benign, the other in pernicious anemia, amounted to begging the question. Ehrlich's advice in such a predicament, to keep on looking and be guided by other nucleated cells, is not of much assistance in cases such as he mentions, where only one nucleated but uncertain red cell can be found in several preparations. Some observers have counted only typical cells, leaving others out of consideration. Most frequently a prolonged examination will enable us to recognize the preponderance

of either normoblasts or megaloblasts, but at the same time I think it important to pay more attention to the atypical nucleated red cells and to carefully describe them. Many of them are doubtless degenerating normoblasts or megaloblasts, others still more closely resemble the cells found in the earliest months of blood formation. They therefore carry the apparent reversion back to a still earlier stage than do megaloblasts. In practice these "metrocytes" may be considered as of about the same value as megaloblasts, but careful studies may throw much additional light upon the conditions in which they occur.

Though megaloblasts are the most striking features of the blood in pernicious anemia we must remember that besides the difficulty of positively recognizing them, they sometimes occur in other conditions. It is true that these other conditions—acute infections chiefly—can be readily distinguished from pernicious anemia, but the fact remains that no single feature of the blood is characteristic of the latter disease, but that the whole series of alterations must be carefully weighed.

Regarding the prognosis of pernicious anemia, it is not enough now to say that it is unfavorable. In the first place, we must distinguish certain cases of bothrioccephalus anemia, in which recovery may follow removal of the parasites. Syphilitic cases are also relatively favorable, but in these the tendency to relapse must not be forgotten. In many other cases, cryptogenetic after the most thorough search, remarkable improvement may occur, even without special treatment, but more certainly when the most careful treatment has been carried out. A complete recovery can not be expected, in the present state of our knowledge, even in bothrioccephalus cases, unless the cause is removed before the megaloblastic degeneration is ineradicably developed. I have not seen a case of pernicious anemia that I thought had wholly recovered. Several have attained a normal blood count and remained well for one, two or three years. The longest interval, without treatment, was three years and five months, the patient working as a railroad conductor for the time

mentioned. He then had an attack of what was called "grip" and after four months of ill health returned, complaining of shortness of breath and weakness, and with one million six hundred and forty-four thousand red corpuscles, three thousand seven hundred leucocytes, forty-five to fifty per cent. hemoglobin. He recovered enough to return to his work, but relapsed twice at intervals of about one year. One patient, apparently hopelessly ill, with 702,250 red corpuscles, 25 per cent. hemoglobin, and many megaloblasts, is still alive after more than five years, but I have not seen him nor examined his blood recently. Often patients will insist they are well enough to stop treatment, with not more than three million red corpuscles, but even with nearly five million, and ninety-five per cent. hemoglobin, occasional poikilocytes, micro or macrocytes show that the blood is not yet normal. Even in the combination of pernicious anemia and new growths, as of the stomach, considerable improvement may occur.

Can the examination of the blood assist us in prognosis? My own opinion is that it cannot assist us very much. One need examine only a small series of cases to learn that the blood changes have no constant relation to the outcome. In general, cases with less than one million red corpuscles are unfavorable; those with six hundred thousand or less very unfavorable. But even with less than half a million great improvement is possible, and on the other hand a patient first seen with two and a half million red cells, but with megaloblasts and poikilocytes, may steadily decline. So with all the other factors. A low color index may be a good sign, likewise the normal proportion of polynuclear cells and eosinophiles, the absence of marked degeneration of the nuclei and protoplasm of the red cells, normoblasts numerous and megaloblasts few. But there are so many exceptions, and in some cases contradictions, in the various elements, that the prognosis can rarely be based on the blood. In all cases the other symptoms, especially those on the part of the alimentary canal, are of cardinal importance. Practically, one should begin the treatment of a case of pernicious anemia

with the hope of improvement for at least some time and be guarded in the expression of a prognosis as to duration. Even with apparent general improvement, it is necessary to follow up the conditions in the blood by frequent examinations, for unfavorable changes are often first shown there.

The treatment of pernicious anemia is a large subject and I shall not attempt to do more than outline it. It may seem trite to say the patient is to be treated and not the disease, but nowhere is the statement more applicable. We often see cases that have improved much under the simple administration of arsenic, and we sometimes see improvement without any treatment, but in most cases it is only by answering every indication that good results can be expected. Causal treatment, in cases with parasites or syphilis, is understood as a matter of course.

In the majority of cases the alimentary canal requires treatment, and this often begins with careful work on the part of the dentist, or by the use of the toothbrush with antiseptic mouthwashes.

A test meal or rather a series of test meals, should early be given and the anatomic and chemical conditions in the stomach cleared up as much as possible. Hydrochloric acid is almost always indicated and often lavage is necessary.

The diet must be laid out in detail, with reference to the conditions in stomach and intestine, and care taken that the directions are followed. The bitter tonics can often be used with advantage.

Constipation on the one hand, diarrhoea on the other, require appropriate treatment. Intestinal antiseptics are sometimes of distinct benefit. In one of my cases there was frequent and troublesome diarrhoea. The patient herself found that salol was useful for that symptom, and took it in large quantities for five years, during which she had three severe relapses. Arsenic was not well borne, and though various other things were tried, the salol seemed most useful.

In many cases weakness is so marked that the patient must be put to bed and massage given. Friction with cod liver oil or alcohol can often be used with benefit.



The patient must always be warned against the danger of over-exertion. Relapses sometimes quickly follow errors in that regard.

Bathing should be practiced according to the strength. Cold friction, or the cold spray or douche, should be used whenever possible. Not the least important aid in my opinion is fresh air. For several years I have kept anemic patients in the open air, just as in the treatment of tuberculosis. Many of them spend the entire winter day on open balconies with manifest advantage.

The relapses should be looked for, and not allowed to go far without treatment. The patient must be impressed with the necessity of having the blood examined at intervals, even when he is apparently well. The relapses may come on at any time, but especially after any depressing incident or disease. They are more likely to occur in winter and spring. I think lack of fresh air is a more important factor than cold in these cases, and advise all my patients either to go to a warmer climate and live out of doors or to take open air treatment at home at such times.

I purposely mention last drugs that are supposed to act on the blood-forming organs or the blood itself. As long as we know so little of blood formation and the action of drugs upon that function, it is impossible to speak positively of the position of arsenic, which is so widely used as a specific in pernicious anemia. That the drug has a beneficial action on the blood I do not think can be doubted. In many cases we see the blood get worse in the beginning of its use. That has been explained, and with some reason, as due to increased break down of imperfect cells, but it may be due to an irritant action in the hematopoietic organs, followed in favorable cases by stimulation. In either case the treatment is not ideal, for it does not, so far as we know, reach the cause of the disease. It may be useful, however, in tiding the patient over a time during which the primary disease is being dealt with by the recuperative power of the body. It is important to remember that some patients cannot take arsenic by the stomach in any form. In such cases the hypodermic method may be tried, and will

sometimes seem useful. According to any theory we can form of the action of arsenic in pernicious anemia, it must be given in such doses as have a distinct effect on the body. Accordingly, the blood and the alimentary canal must be carefully watched during its administration.

Iron is often said to be useless, sometimes even dangerous in pernicious anemia. Like arsenic, it sometimes seems to cause a temporary deterioration of the blood, but I have often used it with apparent gain, alone or with arsenic. The fact that there is an excess of iron in the liver cells does not seem to me a good reason for withholding that drug. We know that in other anemias iron often seems to do good when the natural sources of iron show no fault.

I often use with satisfaction a drug rarely mentioned in this connection, viz., bichloride of mercury, and not only in syphilitic cases, but in others. It acts, in my opinion, much like arsenic, by irritating the blood-forming organs. It can often be combined advantageously with arsenic and iron, as well as hydrochloric acid, the dose of each being carefully adapted to the case.

Time is too short to speak of all the details in the treatment of pernicious anemia, nor is that necessary. If I have contributed at all to the closer study and more thoughtful treatment of the conditions that go under that name I shall have gratified my own hopes and expectations.

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### MALIGNANT DISEASE OF KIDNEY IN CHILDREN—REPORT OF CASE WITH OPERATION.\*

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BY J. F. PERCY, M. D., GALESBURG.

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Pathological Report by,  
WILLIAM H. WELCH, M. D., BALTIMORE, MD.

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The modern surgeon can probably date the beginnings of his knowledge of neoplasms in the kidney from 1883 when Grawitz published a paper calling attention to certain tumors which had previously not received a correct pathological interpretation. Before

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\*Read at the 53d Annual Meeting, Quincy, May 20, 1902.

the time of this writer, and even since, these growths, because of the complicated structure of the organ from which they spring, have not lent themselves readily to the necessarily limited knowledge of the pathologist. It is only in this way that the conflicting views regarding the origin of tumors of the kidney as shown by the aberrant nomenclature, can be accounted for.

Because of this fact, recent writers on the subject of malignant disease of the kidney, have urged the necessity for more careful reports, both clinical and pathological. It is not my purpose therefore to go extensively into the published results of the work of investigators in this special field, except in so far as they may help me in explaining to you more perfectly the case I wish to report. Permit me then by way of preface, to briefly add some of the observations made by those who have contributed to this department of surgery.

As to frequency, one author in 1,400 autopsies, reports the finding of but six primary renal tumors. Virchow makes the statement, based on his enormous experience, that the rate of frequency is half of one per cent. All writers on this subject, agree that this relative degree of occurrence is the rule.

Another fact agreed upon, is the great rarity of secondary involvement of the kidney by malignant growths. One author (Eisendrath) commenting on this, says: "These metastatic tumors do not reach any considerable size, and are generally not numerous. They might therefore be left out of consideration for surgical purposes in speaking of renal neoplasms." This author also refers to the infrequent involvement of the kidney by benign growths. Thus, of 356 cases, 329 were nearly equally divided between sarcomata (187) and carcinomata (142), leaving but 27 of the growths found in these organs in the benign column. This leads Eisendrath to observe: "We thus see that for clinical purposes we might leave out the benign forms of new growths."

Another fact of speculative interest is the early age at which the majority of the malignant tumors are found. Kelynack

quoted by Eisendrath, shows that in 160 cases, over 52 per cent. occurred below the age of 10 years, and 60 per cent. of these below the age of 5 years.

Pathology, since the time when Virchow first announced his theory of cellular life, has explained the abnormal tissue growths with which it mainly deals according to this theory. Cohnheim added a subtle element of probability to this theory when he referred every tumor to its proper embryonic layer, and claimed that a tumor never had its origin from mature tissue, but always developed from a matrix of embryonic tissue. This essential tumor-matrix he traced back to its embryological source. How greatly this theory has influenced writers on malignant disease of the kidney, can only be appreciated by looking through the literature. No other explanation seems to be thought of, let alone attempted. The fact is referred to that embryologically, the development of the kidney is very complex. That cell inclusion is a common accident. But along this line sight seems to be lost of the fact that vital organs, other than the kidney, have a complicated structure and yet are not subject to the destructive presence of abnormal growths in anything like the same degree. As long as no one has said—"I know," is it unscientific to call attention to an old fact known to every one and to ask if it may not apply here, viz: That the period of life classed as childhood is peculiarly interesting because of its susceptibility to certain diseases of an infectious nature. It was shown above that the period of life in which the greater number of malignant neoplasms of the kidney become manifest, was below the age of ten years. The same thing is true as to the age for the development of the greater number of cases of scarlet fever, diphtheria and smallpox, diseases in which kidney complications are exceedingly common. Measles does not apply here because the greater number of deaths in this disease occur more than two years earlier than in those mentioned above, and besides, measles is a disease in which kidney complications are rare. In other words, it would seem that there is an unvarying period in life in which the vulnerability of the kid-

ney to certain changes reaches its maximum. The theory of pathology announced by Cohnheim does not and cannot, as far as I can discern, help us to explain these facts.

Is it not interesting that cell inclusion is prone to manifest itself in the kidney about the same periods of time in which diseases known to be due to infection, develop? Diseases too, which frequently damage the kidney to a dangerous degree. And yet, cell inclusion is not now considered as one of the abnormal processes in the body which is influenced by bacteria.

Does it not look as if the kidneys were compelled at times to attempt the elimination of organisms other than those recognized now as causing the acute infections? Failing in this, is it strange that we should have manifestations of disease which, when they appear, we give the rather generic term of malignant.

What I have said so far, refers only to the early periods of life. Malignancy, barring the kidneys, is in the majority of cases, a disease of late adult life. Why it does not develop late in life in the kidney, may be due to the increased resistance to its cause as is the case in scarlet fever, &c. Again, if lessened resistance in childhood be coupled with the fact that the kidney is an eliminating organ and in this way, peculiarly exposed to infection, the resemblance to some of the well-known infectious diseases of early life is still further maintained. When the kidney escapes this infection in early life and the individual in his adult years develops cancer, does it not merely prove that, either the infections of malignancy is very slow in its development, or that in the later years he again becomes vulnerable to the same kind of lessened resistance which in the case of the kidney at least, is the rule in the young.

The most important fact that has been learned regarding tuberculosis is the slowness with which the infection progresses to a point where it can be recognized. Lessened resistance then, in the kidney of the young to malignant infection, just as in them there is a lessened resistance which manifests itself when attacked by certain of the infectious fevers.

Another problem of importance, it seems to me, against the embryonal theory of malignancy, is this: man cannot protect himself against errors in the creative element of his development. But through knowledge gradually acquired, as knowledge is usually acquired (through necessity), he can protect himself against the agents who would undo him. One of the greatest triumphs won by man in all time, is the knowledge which he now possesses that there is infective disease producing agencies of which he must have a perfect knowledge before he can hope to master them. If they are born in him (embryonal), then he can do nothing, because with creation he has never had anything to do.

Cell inclusion may be a normal physiological process. I have not been able to learn that any one has undertaken seriously to prove that it was. Since the time of Cohnheim, everything has been done to prove that it was not.

John C., American, Aet. 15. His father who was a physician died by an accident. The mother died of tuberculosis at the age of 38. Her mother also died of tuberculosis at the age of 40. Grandparents lived to an advanced age. There are no other cases of tuberculosis in the family, and aside from this, the family history is negative. No past history of injury was obtainable when the patient consulted me. His life had been remarkably free from the common diseases of childhood. He was well nourished and there was no suggestion of cachexy except the unusual fairness of his skin. He had in a marked degree the look of health. He was not as mature, perhaps, as many boys of his age and I learned that he did not care for the sports that boys usually enjoy at his time of life. The patient was brought to me July 8, 1898. For five months previous to this time, he complained at frequent intervals of severe headache and of a constant dull pain in his left side, (left lumbar). About this time he began to grow languid and was not so strong physically. There is no history of a urinary examination previous to this time. When he came under my care the urine was normal.

July 4, 1898, he was seized suddenly with



severe, generalized abdominal pains. A physician was summoned and some relief given. He did not improve however, as far as the relief to the abdominal symptoms was concerned. The pain and failure to move the bowels persisted to such a degree that the physicians in charge were forced to a diagnosis of intestinal obstruction. The history obtained at the time, shows that the bowels had given no trouble until July 1, 1898. On that date, trouble was experienced by the patient in getting the bowels to move and this difficulty increased until constipation became absolute. The physicians first saw the patient July 4, 1898. The next morning a tumor was discovered in the upper part of the left lumbar region near the border line with the umbilical region. It was freely movable and gave every evidence of being connected with the bowel. A diagnosis of intussusception of the gut was ventured. The case was sent into the hospital for operation. I failed to make a diagnosis other than that already made. The patient was placed in the extreme Trendelenburg position. An anesthetic administered and water forced into the bowels with the hope of overcoming the suspected introversion of the intestine. This was done the day the case came under my care. It was interesting to note that after filling with water, the percussion note over the line of the bowel was devoid of its tympanitic quality up to the lower pole of the obstruction. Immediately beyond, it was normal. This seemed to confirm the diagnosis previously made. This is interesting in the light of the correct diagnosis which was made later by the aid of an exploratory incision.

Of even greater interest is the fact that the bowels could not be made to move in any degree by the copious use of the water. The water when it was allowed to return was but slightly stained by fecal matter and it had no odor. In this case, as operation proved, there was no diminution in the caliber of the gut; but effective peristalsis was inhibited completely. I should add, that the tumor, when the gut was filled with the water, could be made to change its position only when the gut was moved, either by manipulation through the abdominal walls or by changing

the position of the patient. I should also state, that the kidney was not thought of as a possible explanation of the cause of the trouble. The true nature of the origin of the symptoms was only brought about through an abdominal section which disclosed an interesting state of affairs. One pole of the kidney had fastened itself to the ascending colon through the parietal peritoneum. The union was not so strong, but what an easy separation between the colon and kidney was obtained. It left the former with a denuded spot on its serous surface about one and a half inches in diameter. This accounted for the obstruction of the bowels. Besides the abnormality between the colon and kidney, the abdominal lymphatics were here and there greatly enlarged (about  $\frac{1}{2}$  inch). From the macroscopic appearances, tuberculosis was thought of as the primary cause of the trouble. As soon as the true condition of affairs was recognized, the abdomen was closed and the kidney removed through the lumbar incision. Before closing the abdomen, the right kidney was palpated and found apparently normal. The left kidney and ureter were completely removed. This means that the fossa for the kidney was thoroughly stripped and that the ureter was removed down to the bladder. Recovery was complete and without incident.

After leaving the hospital, the patient passed through an interesting series of changes. The most pronounced of these were connected with nutrition. His whole character changed. Whereas, before the kidney was removed, he was quiet, non-assertive, almost effeminate, after its removal, he became active and aggressive. In other words, a boy with all the characteristics typical of that gender. The first thing after getting out of the hospital was a shot gun. He was taken to the home of a sister in the northern part of the state and thus passed from under my direct observation. The family was qualified to correctly observe his symptoms. They reported that his condition remained perfectly satisfactory; i. e., he was fat, attended school and seemed to enjoy everything until the following December (1898). In January (1899) while on a hunting trip,

the patient had taken a severe "cold" and with its onset, two convulsions developed. Unfortunately, no record of the urinary examinations made at this period was kept. From this date until his death, he was confined to his bed the greater part of the time. In May he suffered intensely from headaches and complained of a roaring, gurgling sound in the head which he likened to a train of cars crossing a long bridge. Over the region of the anterior fontanel, a marked swelling developed. Dating from the attack of "cold" in January until within three weeks of his death, the patient expectorated quantities of brick dust sputum. These symptoms were undoubtedly due to secondary involvement of the lungs and brain. Three weeks before his death which occurred July 22, 1899, the convulsions increased in frequency. In the intervals the suffering from the headaches was so severe as to require morphine until death made its use no longer necessary.

This history suggests inquiries, the answer to which cannot now (because of the present undeveloped state of our knowledge), be given. What was the very marked mental and physical improvement following the removal of the diseased kidney due to? Physical improvement is not an uncommon concomitant following surgical operations. But mental changes are not so common, except perhaps, in the rare instances where the mental powers have been restored to an insane patient after operation. In the case here reported, they were augmented to a marked degree. Was this awakening due to the ushering in of a delayed puberty? The delay occasioned perhaps, by an inhibitive action on the part of an abnormal growth developing in a vital organ, in this case, the kidney.

As is shown by the accompanying report of Prof. Welch, this growth resulted from cell inclusion from the hypernephron or suprarenal body.

Within a comparatively recent time, investigators along the lines of pathological physiology (if I may be allowed the term) have been compelled to give an increasing amount of attention to the study of the ductless glands. The various changes and

anomalies in and of the thyroid, giving rise to nutritional changes marvelous in their character, is an illustration.

The supra-renal glands which concern us more especially at this time, when the subject of disease gives rise to one class of symptoms which are now given the name of Addison's disease. In another set of diseases, the autopsy reveals hypertrophy or hyperplasia of the adrenal tissue. During life, the subject of this condition is found to suffer from symptoms which would indicate a varying degree of new toxic principles in the organism. These are the cases, the symptoms of which during life are often diagnosed as a renal sclerosis. The pulse is remarkable for its high tension, it is slow and the subject of these symptoms usually has a very white skin, as did the case above reported. Moreover, they frequently die of apoplexy even though they may be very young in years.

I do not want to introduce here, the present much despised subject of therapy by glandular extracts. But I do want to ask this question: Is it not evident that this boy was not getting from his diseased kidney something necessary to his complete physical and mental existence? And that when this diseased structure was removed, the body responded to the general relief secured in this way. If it was not this, the only other explanation that can be given is, that the remaining kidney was forced in this particular as well as others, to do the work of two. It is only in this way that the marked benefit which persisted for six months can be accounted for in this case.

The three points that I would like to emphasize are: That the embryonal theory of the development of malignant growths, has for its main support the theory of Cohnheim; (second) that malignant disease of the suprarenal glands produces changes in the general organism unlike the changes produced when the kidney is the primary source of these changes; (third) the embryologist, the bacteriologist and the pathologist must observe further before important deductions by the physician and surgeon necessary in the management of these cases, are made.

Aloysius O. J. Kelly. Ueber Hyperneph-

rome der Niere. Ziegler's Beitrage. Bd. XXIII.

O. Lunarsch. Beitrage zur Histologie der von Nebennieren keimen ausgehenden Nierengeschwulste. Virchow's Archiv, 1894. Bd. CXXXV. p. 149.

Horn. Beitrag zur Histogenese der aus aberrirten Nebennierenkeimen entstandenen Nierengeschwulste. Virchow's Archiv. Bd. CXXXVI. p. 191.

These articles give full references to the literature.

#### EXAMINATION OF SECTIONS OF DR. PERCY'S CASE OF TUMOR OF KIDNEY.

Report of Wm. H. Welch, Baltimore, Md.

None of the renal tissue appears in the section. There is a new growth composed of cells and stroma. In places, a distinct fibrous capsule enveloping the tumor is apparent, and it is possible that such a capsule was present around the growth. From this growth strands of fibrous tissue are prolonged irregularly into the interior of the tumor. Between these coarser septa the tumor is composed mostly of cells with scanty stroma.

The characteristic cell of the tumor is large, polygonal, with abundant protoplasm, and a large round vesicular nucleus containing a single deeply staining nucleolus. The nucleus is often excentrically placed. These cells frequently contain large and small oil globules, the appearances resembling those of fatty infiltration rather than fatty degeneration. These characteristic cells are arranged in double rows and in alveoli of varying shape and size. They are closely connected with the stroma at the margin of the alveolar spaces. The stroma consists mostly of capillaries with distinct endothelium.

There is considerable necrosis in parts of the tumor so that areas occur without nucleus staining or with fragmented nuclei. There is a moderate degree of mucoid transformation of the stroma. There are likewise, a few foci of old haemorrhage with yellow blood pigment.

#### DIAGNOSIS: HYPERNEPHROMA.

Remarks: Although there is some difference of opinion as to the origin of these

tumors, the evidence seems to be almost conclusive that they spring from aberrant bits of the supra-renal capsule which, during embryonic life, have been included within the substance of the kidney. Tumors of this character have been reported as sarcoma, carcinoma, endothelioma, etc., of the kidney. They have many of the histological characters of carcinoma, but upon the whole, their resemblance is histologically greater to endotheliomata. The name "hypernephroma," signifying that they spring from the "hypernephron" or supra-renal body, was suggested in 1896 by Birch-Hirschfeld, and is perhaps as good a designation as any.

The evidence upon which the diagnosis of supra-renal tumor is based in the present case is the following, distinct fibrous capsule, large polygonal cells with fat drops, arrangement of cells in columns (as in zona fasciculata of supra-renal) and in alveoli, close relation of cells to walls of capillaries and occurrence of necroses, all of which are characters common to this form of tumor.

This type of tumor is the most common of all renal tumors, more common than cancers and sarcomata originating in the tissue of the kidney itself.

The present tumor must be regarded as malignant. There is a marked tendency to metastasize through the blood circulation, the first metastases being usually in the lungs. Metastasis rarely occurs through the lymphatics which is a point of contrast with the true cancers of the kidneys.

The prognosis in the present case depends altogether upon whether cells of the tumor become inhibited throughout the blood-current before operation. If not, the prognosis would be favorable. This is a matter which of course can be decided only by continued observation. There is no evidence of tuberculosis in the specimen.

#### Discussion.

Dr. Edward H. Ochsner, of Chicago: Mr. President—I do not think such a paper as this ought to go by undiscussed. It opens up a question which has caused the best pathologists and best surgeons a great deal of trouble, but I think we are making some progress, and that some light has been shed on this subject.

Some six years ago Grawitz, of Vienna, called attention to the fact that suprarenal



tumors of the kidney were the result of extreme high blood pressure. He made this postulate from a small number of cases. Later, Sippy, of Chicago, added one or two cases which furnished additional evidence in proof of that statement, and we have here another case which results in the same conclusion—high blood pressure, with, later, hemorrhage into the brain, with death. It is only after getting complete reports of such cases that we are able to draw deductions. It is reasonable to suppose, from the number of cases we have heard and had reported, that when we have a tumor in the region of the kidney, accompanied with high blood pressure, it is a suprarenal tumor of the kidney. Of course, we have not enough cases to make this statement with absolute certainty, but we are gradually accumulating evidence to that effect. Grawitz was the first to call attention to this kind of tumor, and later an error was made in calling all tumors of the kidney which seemed to correspond to such a type as aberrant suprarenal tumors. Sudek, of Hamburg, after considerable investigation, proved that a great many of these tumors were not suprarenal, but maintained that there should be two great classes, one a true suprarenal tumor, and the other adenoma. He also made the statement with some hesitancy that in the one case there was high blood pressure, and the tumor was malignant, and the outcome problematical, but usually fatal, while the other tumor was benignant, unattended with high blood pressure, and the outcome, after an operation, was very much better.

**Dr. Daniel N. Eisendrath**, of Chicago: The ground which I intended to cover, in speaking of the pathology, has been completely gone over by Dr. Percy, and it scarcely seems necessary to mention more than that this is a most interesting tumor. It is a class of tumors, as Dr. Ochsner has stated, concerning which our knowledge has been advanced within the past ten or twelve years since Grawitz and Sodek have added their work. For a long time there was considerable dispute as to where these tumors originated. The general opinion now is that they originate from the suprarenal capsule.

The only points of interest are those in regard to the diagnosis of suprarenal tumors in children. For practical purposes, we have two classes, the sarcomata and the hypernephromata. As regards the hypernephromata, they are much more inclined to be accompanied by hemorrhage in the urine than sarcomata. The sarcomata show themselves much earlier than the hypernephromata. On the one hand, in order to make an early diagnosis of tumors of the kidney, we have only to rely upon diagnostic symptoms upon which reliance can be placed, namely, the presence of a tumor and hematuria. In the class of tumor described by Dr. Percy, I do not know whether he referred to the examination of the urine or not, but he tells me that, contrary to the general opinion, hematuria is one of the early symptoms of this class of tumors.

## WHAT SHOULD BE THE ATTITUDE OF THE MEDICAL PROFESSION TOWARD THE SECULAR PRESS.\*

J. W. PETTIT, M. D., OTTAWA,

In scientific advancement the medical profession very justly enjoys the distinction of being one of the most progressive of the sciences or professions. The rapid strides made during the past two or three decades have made it necessary to more than double the time of the college curriculum. Now that the time limit of the college course seems to be reached, the problem presents itself of how this vast accumulation of knowledge can be so arranged as to enable the average mind to compass it. In the rapid march of achievement our minds have centered upon the purely scientific aspect of our profession to the exclusion of collateral interests, which may be less fascinating, but none the less important. The general awakening of the profession to the necessity of organization, which is now recognized by the greatest activity ever known in our history, is simply preliminary to a readjustment of our relations to the new conditions and problems presented by our modern civilization.

In our ethical relations the tendency in the past has been to extreme conservatism—a conservatism that led to a monkish exclusion, almost, in our relations to those who differed with us in methods of practice, and, also, to the secular press. Our attitude toward the irregulars contributed to the formation of medical sects who are very largely indebted to the hostility of the regular profession for much of the success which they have attained. The spirit which prompts medical men to jealously guard the honor of the profession is in the highest degree commendable. We should never depart from this as a principle, but always be ready to change a policy when clearly shown to be wrong.

This society was the first to break down the barrier of sectarianism in medicine—a barrier erected with the purest of motives,

\* Read at the 53d Annual Meeting, Quincy, May 20, 1902.

but maintained for many years by unreasonable prejudice based upon a blind veneration for a provision of our code of ethics bred more in ignorance than in knowledge. The action of this society at its last meeting in unanimously refusing to longer be governed by a tenet of the code, which to say the least, had out-lived its usefulness, was as unanimously approved by the better class of medical men everywhere. This demonstrates that ethical rules in this important particular needed readjusting, and leads to the thought that there may be more work for us to do along the same line. This is my reason for presenting the topic of this paper for discussion.

There is no precept of our code which meets with such universal approval, and the infringement of which is so quickly resented by the reputable element of our profession, as the one which prohibits advertising of that fraudulent and offensive kind that is so justly obnoxious to the ethical sense of every honorable and self-respecting physician. Our position on this question needs no defense, or even explanation, involving, as it does, the fundamental principle that fraud and deception are always and unequivocally wrong, and never more so than when practiced upon the defenseless sick and ignorant. This is so true that it is impossible to conceive of any change in our environment that will ever make any departure from this ethical standard necessary.

The only phase of the subject which presents itself for discussion involves the method of application of this principle, and not the principle itself. In other words, whether we have not included more than is consistent with a proper application of the principle, thereby refusing to avail ourselves of agencies which can and should legitimately be used for the advancement of medical science, and more particularly, in its application to the common welfare.

No agency is more potent for good or evil than the secular press. By secular press I mean more particularly the newspaper, which each day reaches fully ninety per cent of the reading public. By far the larger part of the public, especially busy people, get about all their general information from the news-

paper. The newspaper is the only printed source of information for fully one half of the reading public. It is the purveyor as well as the conveyor of information, the average editor is actuated by as praiseworthy motives in his field of activity as we are in ours. From being simply a record of events, the newspaper now covers every field of human endeavor even to the extent of maintaining departments for the teaching of technical knowledge, which, though crude and imperfect as yet, is an effort in the right direction.

The editor is usually a broad gauge man, who is deeply and conscientiously interested in the welfare of humanity. If his columns do not always seem to bear out this statement it is because he must give the people what they demand. The newspaper is not only the mold of public opinion, but the leader as well. At the same time it must supply the facts, fancies and fallacies on which public opinion is based. In doing this the editor is often accused of pandering to a vicious public sentiment. The successful newspaper man is keenly alive to the fact of what is news, and what is not. He knows that the public does not buy his paper for his opinions, but for happenings of the day. This he must supply because the public demands it, and often times in a manner contrary to his ethical sense. But by giving the public what it demands, he, at the same time, by rare tact and finesse, guides his readers to a higher plane of thought and action. He is to the public what the wise wife is to her husband, "While she bends him, she obeys him." While there is still room for improvement, the newspaper of today is conducted on a higher plane than at any time in the history of journalism. Space formerly devoted to the sickening details of a murder, a hanging or a social scandal is now devoted to the more profitable dissemination of useful knowledge, and no item of news is seized upon with greater avidity, or finds space more readily than a scientific fact, and particularly one pertaining to the promotion of health or the cure of disease.

If the average newspaper medical item is frequently ludicrous, and almost always

erroneous, is it the fault of the editor who does the best he can to get this information, or of the physician, who, through the wrong application of a correct principle, in regarding all newspaper mention of himself or his profession as advertising, refuses to co-operate with the editor in giving the people what they want, and what they have a right to demand, through the only practical agency made available to them? While it should always be regarded as extremely unprofessional to advertise in the sense in which this term is ordinarily understood, are we not over-scrupulous and unduly sensitive in regarding every mention of the doctor's name in the columns of the newspaper as advertising? Is it not a wrong application of a correct principle when we make it unethical for a physician to discuss medical topics in the secular press, or cast suspicion upon him because his name happens to appear in a newspaper column? This unreasonable criticism and censorship has been carried to such an absurd extent that the truly honorable, ethical physician not only seeks to prevent the use of his name in the secular press, but feels that he is placed on the defensive if it even appears without his knowledge or consent.

To illustrate: Only a few months ago an article appeared in one of the leading Chicago dailies giving a description of one of the principal hospitals in that city. There was nothing in the article of especial interest to the medical profession, but much to interest the public. Among other items were the names of the medical and surgical staff with a complimentary reference to their professional ability, which was not fulsome or undeserved. These gentlemen, knowing how squeamish their medical brethren were on this point, felt called upon to disclaim that they had been privy to its publication. In seeking to square themselves with their profession for a fancied offense against an ethical propriety, they violated the very provision of the code, they were seeking to uphold (If we accept the usual interpretation) by still further advertising themselves. Ingersoll, or some other eminent divine, has said that "Any theological dogma carried to its logical sequence ends in an absurdity."

May this not be true of a rule of ethics when too rigidly construed?

But does our code warrant such a construction? Are we not making it include more than its language permits, or than was originally intended? The code says: "It is derogatory to the dignity of the profession to resort to public advertisements, or private cards, or handbills, inviting the attention of individuals affected with particular diseases—publicly offering advice and medicine to the poor gratis, or promising radical cures; or to publish cases and operations in the daily prints, or to suffer such publications to be made; to invite laymen to be present at operations; to boast of cures and remedies; to adduce certificates of skill and success, or to perform any other similar acts. These are the ordinary practices of empirics, and are highly reprehensible in a regular physician." No honorable physician will demand a lower ethical standard than this, and even the newspaper fraternity, who represent the only interest that can possibly be affected by adhering to this standard, will recognize the equity of such a rule of conduct. I insist it is not the code that is wrong, but our interpretation of it.

We deprecate the ignorance and duplicity of the public in being fleeced by quacks, dosing themselves with useless and injurious patent nostrums, and rallying to the support of irrational medical fads. We complain of the secular press for inserting patent medicine and quack advertisements, for giving publicity to medical fads, for which they receive pay, and then refuse to avail ourselves of this same agency for the dissimulation of the truth "without money and without price," because of an unreasonable prejudice. Because the newspaper inserts the quack or patent medicine advertisement, we criticise and ostracise it. The editor does not employ the quack or dose himself with patent medicine, but usually employs the educated physician. He does not, as a rule, even give them editorial endorsement, hence is not responsible for the advertisement. He simply sells his space, which is perfectly legitimate.

How does our attitude toward the secular press materially differ from that of the re-



ligious reformers, who deface and destroy stately churches, beautiful pictures and statuary because they were used in a religious worship which was obnoxious to them? Or those religious denominations who formerly refused to allow the use of musical instruments because they were made use of for immoral purposes? The failure to discriminate between the use and abuse of things, good in themselves, often leads to very irrational acts.

The question that presents itself to us for solution is this: Shall we refuse to make a legitimate use of the secular press because others, as we believe, use it illegitimately? Shall we secure the good will and co-operation of the secular press by treating it as an ally instead of an enemy? There is nothing more useful and necessary to remove ignorance and misapprehension than authentic information. Why should not we, who are repositories of medical information, avail ourselves of the only channel through which the public can be reached. If the public are left to secure such information as they may, from quack and patent medicine advertisements or faddists, it is very inconsistent for us to complain if that information is misleading. Neither can we refuse to give it to them through the only agency by which it will reach them, namely the secular press.

One of the stock arguments used against discussing medical topics in the secular press is the assertion that the public cannot understand. This is absurd. Public opinion is the great arbiter to whom every question must finally be referred for a decision. It is the tribunal to which we are constantly appealing, individually and collectively. An intelligent conception of a medical problem does not depend upon any other sense than common sense, and it is presumptuous for us to give as a reason why medical topics should not be discussed in the newspaper, that they are too abstruse for the average layman to understand. This is probably true of the purely technical or theoretical, but not of general or practical questions. Any medical proposition that is beyond the comprehension of the intelligent layman, when fairly presented, is likewise too deep

for the average physician, or is too speculative to have much value. Our attitude toward the public is too much like that of many parents who do not realize that their children, no matter how mature, ever arrived at years of discretion and understanding.

Granting that the secular press is a legitimate field for the dissemination of medical knowledge what may fairly be regarded as the range of its usefulness? At present this question can only be answered in the most general way. More definite knowledge must come with the successes and failures that result from experience. The first step necessary is to relieve the truly ethical, educated physician from unfriendly criticism if he ventures to discuss through the medium of the press medical topics of general interest. Under present conditions the physicians who are most capable of enlightening the public, and whose opinions would have weight and influence, will not be heard until this embargo is raised. Relieved of this censorship the better class of educated men will enlarge their field of usefulness by directing public opinion on proper lines, and not leave the laity to get their ideas of medical matters "catch as catch can." For example: See what may be done to correct the erroneous opinions of the public with regard to asepsis and antisepsis. How perfectly absurd and ludicrous many of these are. Their opinions have been obtained very largely through the medium of the secular press. Why not use this same medium to set the public aright? If something is not done the public will, sooner or later, awaken to its own folly, and then a reaction will set in against this great discovery that will impair its usefulness to mankind.

To further illustrate: The public are awakening to the fact that tuberculosis is preventable, and that legal steps should be taken to aid in preventing this dread disease. The public will make those laws, not the physicians, and they will be good, bad or indifferent just in proportion as public opinion is enlightened. This must be done by the educated physicians, and should be done in the only practical way that presents itself, to-wit: through the secular press. The

prevention and not the cure of disease will be the principal work of the profession in the future. We can accomplish little or nothing without the aid of an intelligent public. This same public will not accept the *ipse dixit* of the physician any more than it will of the theologian, and we must give a reason for "the faith that is in us," and in a way the public demands. No argument based upon a false notion of ethics will excuse us for any shortcomings of duty, with what is ever a fair and reasonable public.

Nearly, if not quite all, of the papers read before this section are of interest to the public. They are practically lost so far as the public is concerned because they are published only in our medical journals which the public never see. Suppose the plan was adopted of not only permitting, but requesting the publication in the secular press of papers read before this section bearing on questions of general interest. The stimulus afforded by the larger audience of the public would induce the authors of these papers to make more thorough preparation with the hope that their papers might be published in the daily press with the approval of the society before which they are read, thus giving the views expressed the weight of authority. This plan would also bring up for discussion many topics which are of vital interest, but are now neglected because authors do not care to spend their time in preparing papers requiring much thought and careful research only to be read to empty seats. I am constrained to believe that some such plan would result in making this the most interesting and profitable section in our society and productive of more good both to the profession and the public than can possibly be accomplished under present conditions.

Call this advertising if you will. Whatever tends to bring out the best should be encouraged and not repressed, call it by what name you may. Time was when the physician was known by his dress, stately bearing and pedantic manner. Now he does not differ in dress or manner from the merchant, lawyer or other man of affairs. The influential and successful physician is a good "mixer." He identifies himself with every laudable

undertaking in the community. By this means he maintains and retains a hold upon the people he could not by assuming the air of mystery and exclusion so common to our forefathers. The old-time physician would hardly find a place under the new conditions imposed by our modern civilization. In this intensely practical age there is no place for men or things whose only claim for recognition is because they bear the musty flavor of age. Ours is classed as a liberal profession. Let us show our liberality by conforming to new conditions as they arise. We should use the press without self-advertising, which we all rightly condemn, but to discuss medical questions that are vital to the public, is not only not unprofessional, but is demanded by the public.

We can hardly over-estimate the good that may be accomplished for the public and our profession by such a use of the secular press as I have out-lined. The stock argument that such a use is advertising should not longer serve as a bug-bear to deter us from our plain duty. Our hold upon the public will depend not alone upon the correctness of our medical views, but by having them understood as well. The public will understand just in proportion as we avail ourselves of those agencies presented for our use. The greatest of these is the secular press.

#### Discussion.

Harold N. Moyer, of Chicago: Mr. President—This paper is one which scarcely admits of discussion. The points made by Dr. Pettit are practically self-evident. He has placed us in a somewhat different attitude from what we have been heretofore in our relations with the public press, in that he has given a broader and more liberal spirit. His paper is certainly to be commended, and not to be condemned, in that respect. Of course, some men will make use of it and say that the paper ought to be criticised. Personally, I have always held to the liberal view that Dr. Pettit has enunciated. I always stand in with reporters myself; I encourage them to come to my office to get my interviews (laughter), because it is a part of my business to educate the public, and notwithstanding the purity and integrity of my motives, I have been criticised. That has been very painful to me, but I am going on in the same way, conscious of my rectitude, and I am glad to have the approval of Dr. Pettit. I am going on further and even harder.

L. Harrison Mettler, of Chicago: The



question is one we are all interested in. There are notices appearing in the daily press of varied character that should receive discussion, and are setting young men to think, What are ethics, and what is advertising? I think the whole question turns on the one word advertising. There are things that should appear in the press, such as, for instance, those referred to by the reader of the paper. I believe it would be the means of doing a great deal of good if certain things to which the essayist has referred were published in the newspapers. Personally, I cannot see that such papers as this, or similar ones that have been read before medical societies, would be any indirect advertisement to the authors, that is, I mean advertising in the offensive sense of putting one's self forward in such a manner as to advance his material interest. But when other items appear in the daily press, appointments giving a man's standing, reputation, methods of study abroad, or somewhere else, which the public are not specially interested in, that is not educating the public. A man may be innocent of having such information appearing therein. Many men get their names in the daily papers without knowing anything about it, and it looks suspiciously like an advertisement. It looks very much as though it were literally and broadly interpreted, "I am So and So; come to me and I will tell you what I am doing." But I want to uphold and commend the spirit of Dr. Pettit's paper; that we should make use of the public press, because the rise of quackery and the spread of it are undoubtedly due to the fact that the public are getting their knowledge of medicine through quacks and quack advertisements, and we simply fold our hands and say how good we are. I believe it is eminently proper for members of the medical profession to write on medico-lay or sociologic subjects and attach their names to articles, or, at least, their initials, or without any name at all appearing. But imagine a well-known banker being called upon to discuss some important financial question, and an article appears in a newspaper without his name attached to it, because he is capable of discussing this financial question from a broad standpoint. I see no reason why the medical profession cannot take the same stand and make use of the lay press in instructing the people on general broad subjects.

**J. F. Percy, of Galesburg:** I will detail an experience the physicians of Galesburg have had in this matter of advertising, in order to show it is not always possible to keep one's name out of the newspapers. If there are any Galesburg physicians present, I know they will bear me out in the statement I am about to make. If there is any man in that city, who has tried conscientiously to keep his name out of the newspapers, it is myself.

In a matter that was of a great deal of interest to me some years ago, and was anxious not to have my name appear in the newspapers, I went to the newspapers before this matter was to come up, and I got a distinct and

honest promise from the editors of two leading papers in Galesburg that my name should not be mentioned in connection with this matter, because if it was mentioned it would not appear except as an advertisement. The matter was agreed to, but it was violated by one of the men and made a great deal of trouble. A column and a half or two columns of matter appeared in one of the papers, necessitating a great many explanations on the part of the other newspaper why it did not mention that matter of news. I want to make this point: There are many times when it is absolutely impossible for a man to keep his name out of a newspaper because the business of the newspaper is to advertise, or, at least, report the events that happen in the town in which the person about whom they write resides. This matter irritated me not a little, and I felt, in a way, that I had been sort of slain. I got the physicians of Galesburg together, and the majority of them talked the matter of advertising over in all its relations, and we finally got a committee of the editors of our papers together and submitted to them this question, What will you charge us as individuals, or so many of us, not to advertise any quack who applies for advertising space in your journals? They had a meeting, and they said to us, We will charge fifteen of you men seventy-five dollars apiece not to accept any advertisement from any quack that applies for the patronage of the public through our daily newspapers. We accepted the proposition. It seemed as though the matter would be brought to a successful termination, when one man of the fifteen men adopted the plan of paying ten cents a line for personal notices in the newspapers. He got the opinion of an attorney, which was read at the meeting where this was afterwards to be adopted, and the outcome of it was that the resolution or proposition fell through, the opinion of this attorney being that we were putting ourselves in a position of establishing a trust, and that we would be thereby robbing other people of their right to earn a living. But this simply makes or establishes the point, that we cannot always keep our names out of the newspapers, and our best intentions may be violated by one or more newspapers.

**Alexander Hugh Ferguson, of Chicago:** I have always been one of those who did not stand in with the newspaper reporters, who did not pay twenty-five dollars or more to have my name flaunted in the public press, and who did not believe in advertising myself professionally. I have been asked to pay from ten dollars to fifty dollars at a time for personal advertising, but have positively refused.

I wish to commend the paper of Dr. Pettit in many respects, although I can see some danger of having the idea go out among the profession that they are at liberty to advertise in the public press, for that will be the general construction put upon this paper. You will find something like this: A student of today will locate alongside of Dr. Pettit and advertise himself as a specialist. He may,



perhaps, get hold of some case of a simple disease and effect a cure with the aid of the grace of God and medicine, and then flaunts this cure in the public press. I think the paper is open to a little criticism in that regard.

As far as state medicine is concerned, I think it is very well presented to the profession already, and the law alone has a good hold upon the laity. There is no objection to printing papers for the public good. I have no objection to it at all myself. There is something besides that the profession ought to do, and that is to educate the people in some way or other, I don't say through the public press, but educate them in such a way that they will disbelieve in Dowieism and in such nonsense as Christian Science. These sects should not exist, and it is largely our own fault; whether it is our fault in not advertising in the public press or not, I do not know. But I think not. The education of the young men and young women of this country ought to begin in the high schools, if not in the public schools. Every boy, before he attains the age of sixteen, ought to know that gangrene cannot be cured by faith; he ought to know that cancer of the tongue cannot be cured by prayer; he ought to know his physiology pretty well; he ought to know something of the natural processes that take place, and there ought to be some means of educating the people right along those lines, but I doubt whether it is through the public press.

**O. B. Will, of Peoria:** This is a subject that is likely to provoke a never-ending discussion, and it seems to me it is one that practically regulates itself. We all know that physicians are essentially jealous of one another; that they are watching one another all the time, and when I say that this question is one that will likely regulate itself, I mean that the man who desires to maintain the respect of his professional brethren, who has good sense, wisdom and judgment enough to be a physician, is not likely to go beyond where he ought to go in regard to this matter, because he knows that he will lose their respect and esteem. And the man of the opposite character, who cares nothing, will go ahead and do as he pleases anyway. So I think, on the whole, the matter is one which essentially regulates itself.

**Dr. Pettit (closing the discussion):** I will only take a moment to correct an impression made by Dr. Ferguson. The purpose of the paper was to make a distinction between advertising or quackery and the education of the public. I wish it to be distinctly and thoroughly understood that I stand for as high an ethical standard as any of the gentlemen present; I do not stand for it simply because the rules were made fifty or a hundred years ago, but I stand for it because it is right. We modify our views. We have different interpretations. The time has come when we want to recognize the better class of medical men apart from the extreme rigid construction of the code of ethics. Men are breaking over the

line in spite of us; they will continue to do it, and the time is not far distant when the profession will be compelled to accept the position substantially as expressed in my paper. Whether they are willing to do it or not, it will be better to accept the condition gracefully rather than be driven into it. Let us educate the public in regard to certain things which are of interest to them. They must get their information from us regarding certain matters, if they get it at all. We are allowing the quacks to feed the public, and we simply stand by and growl at the newspapers instead of trying to make things go right.

My name rarely or never appears in the local press. I have had to meet the same conditions in my city that Dr. Percy has, and my name is rarely ever mentioned in connection with a case. I have been extremely careful. I am not pleading for myself for a license to do wrong, but simply to do what is right. The probabilities are I will never avail myself of such a means of bringing myself before the public. It is not likely that I would have anything to say which would be of interest to the public. But there are men in this hall who can educate the public upon any question of hygiene, the prevention of disease, etc., if we only raise this barrier. Dr. Quine, Dr. Davis, Dr. Webster, Dr. Mettler, any of those men could educate the public on those questions. It is true, there is a certain amount of advertising which comes from doing such work, but advertising comes from doing good and effective work. Advertising in a commercial sense I would condemn. But supposing we should let this sentiment go out, what will be the outcome? There will be certain disreputable men who will jump over the bar. They will do this, even though they have not done it before. The same high professional ethical standard will prevail that has prevailed heretofore, and I hope always will prevail to keep respectable men straight. A respectable man does not need any assistance to keep himself straight. The man who is not straight as a matter of principle is not straight at all. Ethics will not make him so. If we are a high-minded profession, it is because of the innate principles in the breast of every one of us, and not because of the code of ethics.

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## DIPHTHERIA AND ITS MANAGEMENT.\*

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BY E. A. EDLEN, A. B., B. S., M. D., MOLINE.

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There is probably no disease that has caused more dread and anxiety both to the family and to the physician than has Diphtheria. The great death rate in former years from this source certainly shows it to be

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\*Read before the Medical Association of Rock Island County, February 20, 1902.

one of the greatest enemies of childhood. Although it prefers filth, overcrowding and general unsanitary conditions, it, nevertheless, frequently appears in the most sanitary homes and causes misery and desolation. It is a very treacherous disease and is difficult to guard against, as well on account of its queer paths of propagation as on its insidious character, which sometimes is difficult to recognize. The clinical picture of the malady is very variable and its recognition is sometimes impossible without the aid of modern diagnostic agencies.

The Klebs Loeffler bacillus is responsible in the pure and simple infection, but there is quite often a mixed infection, which renders the disease all the more difficult to manage.

When the Diphtheria bacilli alone hold the ground, the disease is generally easily manageable under the modern serum treatment, but an added infection of streptococci changes the phase of the disease entirely, and a more or less malignant character is assumed. Moreover the diphtheria antitoxine is powerless against these allies of the diphtheria. I am well satisfied that the great death rate is due to the streptococcus infection and not to the Klebs Loeffler bacillus.

The clinical features of the disease varies greatly. There may be a membrane or not. The membrane may be confined to the tonsils or may spread on the pharynx, uvula, nasopharynx, nares, eustachian tubes, and the larynx, trachea, and bronchi. In case the membrane has a white color and confines itself mainly to the tonsils, we may be almost sure that we have a pure infection. In mixed infection the exudate assumes a dirty grayish, yellowish, or dark color, with great tendency to spreading, and the surrounding tissue has a very angry look. The constitutional symptoms assume a more grave character on account of the absorption of the streptococci toxins into the system. The peculiar odor of diphtheria is more pronounced in mixed than in pure infection, being of a very foul and repelling character, and is generally noticed on entering the sick-room.

The constitutional symptoms may be mild

or severe. The disease generally manifests itself by lassitude, headache, fever and impaired appetite. But sometimes the membrane may be well developed before anything unusual has been noticed about the child, not even any complaint about a sore throat. In other cases the symptoms are severe from the outset. It may be ushered in with a chill and high fever and great prostration. The pulse generally corresponds to the temperature the first two or three days before the general system is impregnated with the toxins. The fever averages between 99-108, seldom higher, and the pulse between 90-120. In streptococcus infection the pulse and temperature do not correspond. The pulse may in these cases be from 140-150, feeble and irregular, while the temperature may not rise above 100. Albumen and casts are generally found in the urine the second or third day. The lungs are sometimes invaded, in which case we usually have an added infection of the pneumococcus.

The real danger in diphtheria is the septic invasion of the system by the toxins of the micro-organism. As long as the disease is purely local, there is very little danger, except in laryngeal cases, which are always dangerous on account of the great tendency to suffocation from occlusion of the larynx and trachea by the exudate.

The differential diagnosis between diphtheria and follicular tonsilitis is sometimes difficult and the one may easily be mistaken for the other. In follicular tonsilitis we generally have a yellowish exudate in the tonsillar follicles, but the exudate may occasionally assume the character of a membrane, which, however, generally retains its yellow color, and is less foul smelling than is the diphtheritic membrane. Furthermore, it does not spread on the neighboring tissues, but confines itself to the tonsils. Another character of follicular tonsilitis is the high fever and great frequency of the pulse the first two or three days of the disease. The temperature generally ranges between 102-105 and the pulse averages from 120-140. All the symptoms are of a more acute character in follicular tonsilitis, as a general rule. There is greater glandular enlargement in diphtheria, and, frequently, there is puffi-

ness all around the throat, which is not seen in the other affection.

In way of prevention a great deal can be accomplished. All the children should receive an immunizing dose of anti-toxine. Strict quarantine should be observed in every case, and the parents and nurse should be instructed by the physician to observe as far as possible, the general rules of cleanliness, which go far in the prevention of the spread of the disease. In general practice, when we encounter a case in a family of half a dozen children, and with only two or three rooms in the house, it is almost impossible to entirely enforce the separation of the afflicted one from the rest of the family. There will be more or less intercommunication, and, when a nurse cannot be secured, the mother generally will have to undertake the nursing in addition to her other household duties. In such a case, and this is the general rule in private practice among the working classes, the danger of infection of the rest of the family is materially increased, particularly, since it is almost impossible to make the mother take the necessary precautions. However, we have to insist on cleanliness, as far as possible. The attendant should wash the hands with soap and water every time she has tended to the patient. Everything used in the sick-room should be kept separate, and the utensils should be put in boiling water. The napkins used should be burned immediately. The furniture and bedclothes should not be removed from the room until after disinfection. When the child has recovered it should receive a bath and clean clothes. The room should then be disinfected.

Among disinfectants sulphur still holds its own, although formaldehyde has of late been regarded as more reliable.

The treatment of the disease since the discovery of the anti-toxine, has been to a great extent revolutionized. The diphtheria anti-toxine is undoubtedly a true specific, and, if resorted to early in simple infection, it is curative and materially shorten the time of the attack. The percentage of death rate has materially decreased since the introduction of this potent remedy. If the disease is seen in its earliest stages and anti-

toxine is administered the death rate is practically nil, provided we have to do with only the Klebs Loeffler bacillus. Every case ought to receive an injection of 2,000 units as soon as diagnosed. It is seldom required to give a second dose. However, if the symptoms show no improvement in 24 hours another dose of 2,000 units may be administered. I do not believe it good policy, nor of great utility, to inject great quantities of anti-toxine into the system. A 2,000 units dose, or maybe a repetition once, is all that I think is necessary, because, if the anti-toxine is good for anything, the quantity ought to be enough to render the child immune from further aggress of the diphtheria bacilli. Furthermore we must be content to wait a reasonable time, until the action of the anti-toxine manifests itself, and that can hardly be expected in less than 12 to 24 hours. I have never repeated the dose in any of my patients nor have I in a single case depended entirely on the anti-toxine. I have always used the same additional treatment that I use in cases where I do not use the serum. I have used anti-toxine in about 30 per cent. of the cases, and, although the serum seems to shorten the attack, those treated without the serum have done just as well in every other respect. I always advise the use of the serum, but do not urge it, for the simple reason that I have had just as good results without it in both mild and severe cases.

I have had two deaths in 106 consecutive cases. The first fatal case was that of a boy three years old. No anti-toxine was used in this case, although I urged it very strongly, but the parents would not admit of its use. This case was one of three in a family. All three were tubercular. The disease exhibited itself in the most virulent form in all three. The whole pharynx, mouth, nose and ears were covered with the membrane. The treatment, which will be described later, was carried out vigorously and the result was excellent. On the disappearance of the membrane, in 5-6 days, the whole area was raw and there were several severe hemorrhages in the children who recovered. The child that succumbed refused absolutely to take any nourishment



from the first day he got sick until he died, on the seventh day of the disease. The child practically died of starvation. Rectal feeding was tried, but the food was not retained.

The second case was that of a boy two years of age. When I first saw him the membrane was well developed. The temperature was 102 and the pulse 120. I injected 2,000 units of anti-toxine and also prescribed my usual treatment. In three days the throat was clean. On the sixth day I called in the morning and found the temperature normal and the pulse about 100 and of fair quality. Three hours later I was sent for, but the child was already dead when I arrived.

My treatment in diphtheria is both local and internal. Locally I use peroxide of hydrogen in full strength applied with a swab every hour, until the disease is under control. In case the nares also are affected, I inject the peroxide with a syringe into the nose.

Internally I use the following prescription which may be modified to suit the case. It is intended for a five-year-old child.

R.

Hydrag Chl. Cor., grain one.

Tr. Bellad, drachms one and one half.

Tr. Ferri Chl., drachms three.

Glycerine, drachms five.

Elix. Simplicis Qs. ad., ounces three.

M. Sig: Half a teaspoonful in water every two hours.

This treatment has been very satisfactory in my hands, as the most virulent cases have recovered. As a prevention I give it in half drachms doses every 4 hours, and it seems to have some value as such, as very few become attacked, while under the influence of the treatment.

The after-treatment is tonic and stimulative. In cases of septic invasion of the general system by the toxins, strychnine is the most effective medicine and should be given in large doses. Whiskey will sometimes render good service, but should not be given indiscriminately.

The diet should be liquid, mainly consisting of milk and should be given freely.

## PROCEEDINGS ILLINOIS STATE MEDICAL SOCIETY.

Minutes of the Fifty-Second Annual Meeting  
Held at Quincy May 20,  
21 and 22, 1902.

DR. HARRIS: My point of order is that there are two motions in connection with the adoption of the report of this Committee which are inconsistent. First, there is a motion to adopt the new Constitution and By-Laws, which means the repeal of the old Constitution and By-Laws. This must be done by a separate vote. In the report there is another motion to the effect, that part of the Constitution shall be immediately active, and the Society works partly under the old Constitution, which cannot be done. First, we must vote whether to adopt this Constitution and By-Laws or not; then, if we wish to put any of it in operation at this meeting, it will require the suspension of the rules or a three-fourths vote. We have, therefore, two motions which are dissimilar, and we cannot vote on them as a single motion.

I move, as an amendment, that we vote, first, on the adoption of this Constitution. Seconded.

D. W. GRAHAM: I agree with Dr. Harris, that we should first vote on the adoption of the new Constitution; then let the resolution, which was read by Dr. Ingals, be considered as a separate motion.

THE PRESIDENT: It seems to the Chair that the proper thing to do would be to accept the report of the Committee, discharge the Committee, then adopt the report of the Constitution as presented by the Committee. This is the report of a special committee on revision of the Constitution and By-Laws; that report is before you now, and a motion made to adopt it.

JOSEPH ROBBINS: It seems to me, the question is clearly divisible.

HAROLD N. MOYER: As a point of order, Dr. Harris' motion is not well taken. If I understand Dr. Harris correctly, he stated that one motion is contrary in its essence to another. It seems to me, the Society is competent to adopt the Constitution and the

entire report of the Committee with a single vote, and make it operative tomorrow, next week, or next year, if it sees fit. The resolution read by Dr. Ingals relates to the time when the Constitution shall become operative, and it says that a certain part of it shall become operative now, and a certain part in the future. These are not conflicting at all, but are complementary. Therefore, I should say, Dr. Harris' point of order is not well taken.

THE PRESIDENT: I declare the motion made by Dr. Harris out of order.

DR. HARRIS: I appeal from the decision of the Chair.

The decision of the Chair was sustained by a large majority.

The President then put the motion to adopt the report of the Committee, and it was carried.

E. FLETCHER INGALS: Your Committee would suggest that the following district medical societies be recognized, and that they furnish Vice-Presidents for the coming year. It would be desirable to have the members of these various societies meet and mark out the confines of each district. For the present, these societies will be, the Aesculapian Society, 187 members; Brainard District Medical Society, 53 members; District Medical Society of Central Illinois, 138 members; Fox River Valley Medical Society, 72 members; Military Tract Medical Society, 129 members; North Central District Medical Society, 147 members; Southern Illinois Medical Society, 149 members, and Chicago Medical Society, 1,100 members, approximately. I would move that the societies named be considered our district medical societies for the coming year. Seconded and carried.

D. W. GRAHAM asked whether there was any specified time when the different societies could assemble and nominate their representatives to the Nominating Committee.

The President said there was not, so far as he knew.

DR. GRAHAM then suggested that 12:15 o'clock today be fixed as the time for selecting representatives on the Nominating Committee, which was accepted.

Adjourned.

#### SECTION THREE—FIRST SESSION.

Chairman, J. M. Wilcox, Clinton; Secretary, W. K. Newcomb, Champaign.

J. W. Pettit, of Ottawa, read a paper entitled "What Should be the Attitude of the Medical Profession Toward the Secular Press?"

This paper was discussed by Drs. Moyer, Mettler, Percy, Ferguson, Will and the discussion closed by the essayist.

William A. Evans and Adolph Gehrman, of Chicago, read a paper entitled "The Differentiation of Human from Animal Blood."

Discussed by D. R. Brower and Taylor, and the discussion closed by Dr. Evans.

Denslow Lewis, of Chicago, read a paper on "The Conduct or Management of a Charity Hospital."

Discussed by H. H. Hart and Brower.

H. H. Hart read a paper entitled "The Illegitimate Child," which was discussed by J. B. Bacon and Reed, and the discussion closed by the essayist.

Mr. W. A. Shaw, of Chicago, read a paper entitled "The Work of the State Board of Health."

A. Gehrman, of Chicago, read a paper on "The Control of Vaccines, Antitoxins and Biological Products."

On motion, the chair was ordered to appoint a committee of two to confer with the National Committee on Revision of the Pharmacopeia with reference to making the various sera, such as vaccine, antitoxin, etc., official. The chair appointed W. A. Evans, of Chicago, Adolph Gehrman, of Chicago.

Adjourned.

#### SECTION ONE—FIRST SESSION.

Chairman, R. B. Preble, of Chicago; Secretary, S. E. Munson, of Springfield.

M. S. Marcy, of Peoria, read a paper on "The Treatment of Septic Conditions of the Uterus," which was discussed by Dr. Reed, and, in closing, by Dr. Marey.

H. B. Buck, of Springfield, read a paper entitled "Life Insurance Examinations," which was discussed by Drs. Griffith, Hurst, Stowell, and by Dr. Buck in closing.

Margaret T. Shutt, of Springfield, read a paper entitled "The Acute Gastro-Enteric Infections in Infants."

Discussed by Drs. Walls, Mettler, Cotton, Cook (Chicago), and Marcy; in closing, by Dr. Shutt.

Adjourned.

#### SECTION ONE—SECOND SESSION.

On motion of Dr. Billings, J. B. Herrick, of Chicago, was elected to the House of Delegates of the American Medical Association for the two year term, and L. C. Taylor, of Springfield, for the one year term.

On motion of Dr. Billings, the chair appointed the following nominating committee: Drs. Herrick, Pitner, Mettler, Taylor and Walls.

Frank Billings, of Chicago, read a paper entitled "The Stokes-Adams Syndrome; With Report of Cases."

Discussed by Drs. Herrick, Babcock, Brown (Chicago), Mettler, Boone, and Dr. Billings in closing.

I. A. Abt, of Chicago, read a paper entitled "Report of Ninety Cases of Typhoid Fever in Children."

Discussed by Drs. Dock, Cotton, Sloey and Billings.

A. C. Cotton, of Chicago, read a paper on "The Infant's Clothing."

Discussed by Drs. Danforth, Abt, Bowles, Chapin, Larned, Walker, Rooney, Sloey, and Munson.

Adjourned.

#### SECTION ONE—THIRD SESSION.

The Nominating Committee reported as follows:

Chairman, L. C. Taylor, of Springfield; Secretary, I. A. Abt, of Chicago.

George W. Webster, of Chicago, read a paper entitled "What Should we Teach the People in Regard to Tuberculosis?"

Discussed by Drs. Taylor, Babcock, Brown (Chicago), Matheny, Walker, Pitner, Baer, and the discussion closed by the essayist.

Frank X. Walls, of Chicago, read a paper entitled "Miliary Tuberculosis."

D. W. Reed, of Jacksonville, read a paper on "Senile Pneumonia."

E. C. Franing, of Galesburg, considered "Pathology of the Kidney in Pneumonia."

N. S. Davis, Jr., of Chicago, read a paper on "The Treatment of Pneumonia."

These papers were discussed jointly by Drs. Marcy, Herrick, Ingals, Buck, Babcock,

Pitner, Church, Howard, Munson, Reed (Chicago), and the discussion closed by Dr. Davis.

Arthur R. Edwards, of Chicago, read a paper entitled "Certain Clinical Points Regarding the Use and Indications of the Cardiac Stimulants."

B. B. Griffith, of Springfield, read a paper entitled "What Cures? Primitive Medical Ministrations."

E. Fletcher Ingals, of Chicago, read a paper on "The Prognosis and Treatment of Suppurative Pleurisy."

Discussed by Drs. Davis, Frank, Taylor, and the discussion closed by the essayist.

Charles L. Mix, of Chicago, read a paper on "The Diagnosis of Chronic Interstitial Nephritis, Based upon Physical Findings, Chiefly Cardio-Vascular."

Discussed by Drs. Webster, Mettler, Hensley, Preble and in closing, by Dr. Mix.

L. H. Mettler, of Chicago, read a paper entitled "Exophthalmic Goitre."

Discussed by Drs. Norbury, Horrell, Munson, Bowles, Larned, and Mix, and by Dr. Mettler in closing.

J. W. Hensley, of Peoria, read a paper entitled "Some Essential Points Regarding Chronic Constipation of the Bowels."

M. L. Winstead, of Wetaug, read a paper on "Malarial Hematuria."

E. R. Larned, of Chicago, read a paper entitled "Concerning a New Series of Synthetic Salts; the Nucleids of Iron, Copper, Mercury and Silver."

J. W. Kelly, of Springfield, presented a paper entitled "An Unusual Case of Typhoid Fever."

Adjourned.

#### FIRST DAY—AFTERNOON SESSION.

##### SECTION TWO—FIRST SESSION.

Chairman, E. Mammen, Bloomington; Secretary, Wm. E. Schroeder, Chicago.

Arthur Dean Bevan, of Chicago, read a paper entitled "Surgery of the Stomach," which was discussed by Drs. Ochsner, Andrews, Percy, Harris, Graham, and the discussion closed by the essayist.

J. L. Wiggins, of East St. Louis, read a paper entitled "Traumatic Injuries of the Liver, with Report of a Case."

M. L. Harris, of Chicago, followed with



a paper on "Lymphadenitis and Abscesses of the Liver in Connection with Appendicitis."

H. C. Mitchell, of Carbondale, read a paper on "Appendicitis; When Shall we Operate."

These papers were discussed jointly by Drs. Brown, (Decatur), Grinstead, Williams, Brown (Sycamore), Hurst, Ochsner, Frank, Bevan, and the discussion closed by Dr. Mitchell.

S. C. Plummer, of Chicago, read a paper on "The Hartley-Krause Flap in Hemorrhage from the Middle Meningeal Artery, with Report of Two Cases."

Discussed by Drs. Halstead, Andrews, Schroeder, Kreider, and the discussion closed by the essayist.

J. H. Stealy, of Freeport, contributed a paper entitled "A Plea for More Accurate Diagnosis of Cholelithiasis."

Carl E. Black, of Jacksonville, read a paper on "Spinal Injuries."

Frank P. Norbury, of Jacksonville, read a paper entitled "The Neurological Diagnosis of Traumatic Lesions of the Spinal Cord."

Adjourned.

#### FIRST DAY—EVENING SESSION.

The Society re-assembled at 8 P. M., at the Empire Theatre, and was called to order by the First Vice-President, M. L. Harris, of Chicago.

The President, John T. McAnally, of Carbondale, delivered his address.

Roswell Park, of Buffalo, N. Y., by invitation, delivered the Address of Section Two. He selected for his subject "Surgical Intervention in Borderland Cases."

Charles B. Johnson, of Champaign, delivered the address of Section Three, his subject being "A Country Doctor's Contribution to Preventive Medicine."

The Addresses were interspersed with appropriate musical selections by local talent. Adjourned.

The Society met at 8:30 A. M., and was called to order by the President.

The Secretary then announced the Nominating Committee, as follows:

#### LIST OF MEDICAL SOCIETIES.

##### *County.*

Adams county, L. H. A. Nickerson; Alex-

ander county, W. F. Grinstead; Bureau county, C. H. Kemp; Champaign county, C. B. Johnson; Clay county, E. P. Gibson; Crawford county, I. L. Friebaugh; DeWitt county, J. M. Wilcox; Fulton county, J. E. Coleman; Gallatin county, G. P. Cassidy; Hancock county, W. K. Smith; Jersey county, M. B. Titterington; Jackson county, H. C. Mitchell; Kendall county, R. A. McClelland; Knox county, E. C. Framing; La Salle county, J. W. Pettit; Livingston county, V. M. Daly; McLean county, J. Whitefield Smith; Montgomery county, M. W. Snell; Morgan county, J. W. Hairgrove; Pike county, R. H. Main; Randolph county, J. T. Telford; Sangamon county, L. C. Taylor; Stephenson county, J. Saunamen; Wabash county, J. B. Waxwell; Warren county, H. Marshall; Will county, D. W. Jump; Woodford county, F. A. Stubblefield.

##### *District Societies.*

Aesculapian, J. A. Baughman; Brainerd, S. T. Hurst; Central Illinois, W. H. Sparling; Galva District, H. W. Waterous; Military Tract, R. C. Matheny; North Central Illinois, Roy Sexton; Southern Illinois, Geo. Adams; Tri-County, B. L. Euans; Western Illinois, H. W. Chapman.

##### *Urban Societies, Ex Chicago.*

Centralia City Society, J. W. Armstrong; Decatur Medical, C. Martin Wood; Jacksonville Physicians' Club, A. L. Adams; Peoria Medical, J. W. Hensley; Quincy Medical and Library Association, J. H. Rice; Champaign Medical Library Association, W. K. Newcomb.

##### *Chicago Societies.*

Dermatological, R. R. Campbell; Academy of Medicine, A. E. Halstead; Electro-Medical, A. W. Baer; German, L. E. Schmidt; Gynaecological, J. B. DeLee; Medical Society, F. X. Walls; Medico-Legal, G. W. Webster; Neurological, D. R. Brower; Ophthalmic and Otological, G. W. Mahoney; Pathological, A. R. Edwards; Pediatric, J. C. Cook; Physicians' Club, C. S. Bacon; Rhinological and Laryngological, E. F. Ingals; Society of Internal Medicine, H. N. Moyer; South Chicago, Denslow Lewis; Southwestern, C. H. Miller; Surgical, A. D. Bevan; Medical Examiners, W. J. Butler.

# The Illinois Medical Journal.

The Official Organ of the State Medical Society.

EDITOR—George N. Kreider, A. M., M. D., Springfield.

Official Reporters of Affiliated Societies—

## COUNTY SOCIETIES.

Adams County—Henry Hart, M. D., Quincy.  
Alexander County—J. T. Walsh, M. D., Cairo.  
Bureau County—H. E. Owens, M. D., Princeton.  
Bond County—W. T. Easley, Greenville.  
Carroll County—H. S. Metcalf, M. D., Mt. Carroll.  
Champaign County—A. S. Wall, M. D., Champaign.  
Calhoun County—T. O. Hardesty, M. D., Kampsville.  
Clay County—Warren Eugene Burgett, M. D., Louisville.  
Crawford County—L. J. Weir, M. D., West York.  
Douglas County—W. E. Rice, M. D., Tuscola.  
DeWitt County—J. H. Tyler, M. D., Clinton.  
Edwards County—J. H. Lacey, M. D., Albion.  
Franklin County—W. H. Smith, M. D., Benton.  
Fulton County—D. S. Ray, M. D., Cuba.  
Gallatin County—Geo. P. Cassidy, M. D., Shawneetown.  
Grundy County—H. M. Ferguson, M. D., Morris.  
Hancock County—R. L. Casburn, M. D., Carthage.  
Jersey County—A. K. VanHorne, M. D., Jerseyville.  
Jo Daviess County—D. G. Smith, M. D., Elizabeth.  
Johnson County—J. E. McCall, M. D., Vienna.  
Kankakee County—Henry H. Rogers, M. D., Kankakee.  
Kendall County—R. A. McClelland, M. D., Yorkville.  
La Salle County—W. A. Pike, M. D., Ottawa.  
Lake County—A. G. Haven, M. D., Lake Forest.  
Livingston County—Jno. Ross, M. D., Pontiac.  
McDonough County—R. E. Lewis, M. D., Macomb.  
Macoupin Co.—J. Palmer Matthews, M. D., Carlinville.  
McLean County—E. S. Reedy, M. D., Bloomington.

## DISTRICT SOCIETIES.

Aesculapian—H. McKennan, M. D., Paris.  
Brainerd District—J. L. Lowrie, M. D., Lincoln.  
Central Illinois—F. J. Eberspach, M. D., Pana.  
Galva District—C. W. Hall, M. D., Kewanee.  
Fox River Valley—H. J. Gahagan, M. D., Elgin.  
Military Tract—C. B. Horrell, M. D., Galesburg.  
North Central—Geo. A. Dicus, M. D., Streator.  
Southern Illinois—O. B. Ormsby, M. D., Murphysboro.  
Tri-County—Leroy Jones, M. D., Hoopeston.  
Western Illinois—H. W. Chapin, M. D., Whitehall.

## URBAN SOCIETIES, EX CHICAGO.

Alton Medical Society—Geo. E. Wilkinson, M. D., Alton.  
Decatur Medical—C. Martin Wood, M. D.  
East St. Louis—C. W. Lillie, M. D.  
Jacksonville Physician's Club—D. W. Reid, M. D.  
Peoria Medical—E. M. Eckard, M. D.

Marshall County—W. G. DuFour, M. D., Henry.  
Massac County—C. E. Trovillion, M. D., Metropolis.  
Mercer County—A. N. Mackey, M. D., Aledo.  
Montgomery County—J. M. Trigg, M. D., Farmersville.  
Morgan County—T. A. Wakely, M. D., Jacksonville.  
Knox County—G. S. Brown, M. D., Galesburg.  
Ogle County—H. A. Mix, M. D., Oregon.  
Perry County—J. W. Smith, M. D., Pinckneyville.  
Pike County—R. H. Main, M. D., Barry.  
Pope County—W. S. Dixon, M. D., Rosebud.  
Pulaski County—Chas. J. Boswell, M. D., Beechwood.  
Rock Island Co. Ass'n—Jos. DeSilva, M. D., Rock Island.  
Saline County—J. K. Baker, M. D., Harrisburg.  
Sangamon County—F. B. Fisher, M. D., Springfield.  
Schuyler County—A. W. Hall, M. D., Rushville.  
Shelby County—A. G. Mizell, M. D., Shelbyville.  
Stark County—M. T. Ward, M. D., Toulon.  
Stephenson County—R. J. Burns, M. D., Freeport.  
St. Clair County—B. Portuondo, M. D., Belleville.  
Tazewell County—C. G. Muehlman, M. D., Pekin.  
Union County—T. Lee Agnew, M. D., Anna.  
Vermilion County—E. E. Clark, M. D., Danville.  
Wabash County—J. B. Maxwell, M. D., Mt. Carmel.  
Warren County—Adella R. Nichol, M. D., Monmouth.  
White County—W. A. Steele, M. D., Carmi.  
Will County—Herbert S. Worthley, M. D., Joliet.  
Williamson County—G. W. Evans, M. D., Marion.  
Winnebago County—S. R. Catlin, M. D., Rockford.

## CHICAGO SOCIETIES.

Academy of Medicine—J. G. Kiernan, M. D.  
Electro-Medical—Richard H. Street, M. D.  
German—Karl Doepfner, M. D.  
Gynecological—C. S. Bacon, M. D.  
Medical Society—F. X. Walls, M. D.  
Medico Legal—N. S. Davis, Jr. M. D.  
Neurological—C. H. Lodor, M. D.  
Ophthalmic and Otolological—Brown Pusey, M. D.  
Orthopedic—Edwin W. Ryerson, M. D.  
Pathological—Geo. H. Weaver, M. D.  
Physician's Club—L. H. Mettler, M. D.  
Laryngological and Climatological—J. E. Rhodes, M. D.  
Rush College—J. B. Herrick, M. D.  
Society of Internal Medicine—Robt. B. Preble, M. D.  
Southwestern—Thos. J. McGonagle, M. D.  
Surgical—D. N. Eisendrath, M. D.  
West—Gustavus M. Blech, M. D.

All communications should be addressed to the Editor, 522 Capitol Ave., Springfield, Illinois.

The Society does not assume responsibility for any statements or opinions published in the JOURNAL.

The JOURNAL is published monthly. The subscription price is \$3.00 per annum in advance. The JOURNAL is furnished free to the members of the Society.

Entered at the postoffice in Springfield as second class matter.

JULY 1902.

## PROMINENT FEATURES OF THIS ISSUE.

It has been suggested by one of the busy members of the Society that the matters of particular importance appearing in each Journal be designated each month on the editorial page. In accordance with this suggestion we call attention to the following items:

1. The Revised Constitution and By-Laws as adopted at Quincy.
2. The papers and discussions on proper advertising by medical men, by J. W.

Pettit, J. L. Porter, F. Kreissl, L. H. Mettler and J. W. Walker.

3. The Toast on Medical Societies by G. M. Blech.

4. The papers and transactions of the annual meeting.

## THE COAL MINERS OF ILLINOIS.

To assist the miners now striking in West Virginia the Illinois miners have contributed \$50,000 in cash and the statement is made that in the treasury of their state

and local unions there remains nearly \$1,000,000. The number of miners in this state is 50,000 and so strong is the organization that not one man or boy connected with this trade is out of the union. Such a close organization of our profession is not possible or desirable, but the strength, both numerical and financial of this union, of lowly workers, has certainly a lesson for our 10,000 medical men. In all our societies regular and irregular these are less than 45 per cent. of the total number enrolled and the total amount of funds on hand for any protective work or legislation is probably less than \$2,000. In other words the miners have on hand for their protection and defense \$20 per capita, the medical men for the same purpose 20 cents per capita.

Comment is unnecessary.

#### ORGANIZE THE REMAINING COUNTIES.

The various committees are actively at work organizing the few counties in the State still without the fold. These number about thirty and it is not too much to expect that all will be provided with societies before the next annual meeting. We already have the largest State Society in the Union and by the end of this Society year, should number not less than 4,500. As has been pointed out before, it is not the small and sparsely settled counties which are still to be organized, but rather the large and wealthy counties, such as Lee, Iroquois, Greene, McHenry, Kane, DeKalb, Ford, Christian, Logan, Mason, Piatt, Menard, Cass and Brown. If the medical men in these counties are wise they will at once take steps to get into the band wagon, to use a political phrase.

#### OUR TRANSACTIONS.

While in New York City we were gratified to find in the library of the Academy of

Medicine a set of the Transactions of the Illinois State Medical Society complete with the exception of one year, 1863. Should any of our members have copies of this volume we hope they will forward them to us so that this file may be completed. We are under obligations to Secretary Brownne of the Academy for four volumes of the Transactions of our Society not previously in our possession. As our files are still incomplete we again call on our older members to supply us with copies of Transactions from 1850 to 1875.

#### THE ST. LUKE SOCIETY OF CHICAGO.

During the past month the people of Chicago were horrified by a dreadful fire which consumed a sort of inebriate hospital bearing the honorable name of St. Luke, and with it a dozen of its inmates went to a miserable death. One O. E. Miller, promoter of a hernia cure in Denver in the 90s, and later in Chicago promoter of a mediated sand cure, was the head of this institution. Since the disaster Miller has spent considerable time in the county jail, being detained there to insure his appearance before the grand jury to answer for lives lost in the fire. If anything were needed to show the necessity for strict State control of medical men and institutions this incident would supply it. Every hospital and honorable medical man is interested in this matter.

#### THE SARATOGA MEETING.

After an absence of many years the American Medical Association returned to the State in which it was conceived for a meeting. Thereby hangs a tale of great interest could we but tell it in all its minutia. This being an impossibility we propose to relate only a few of the incidents of the meeting which may be of interest to our Illinois readers.



The meeting was not large. Only about 1,400 members were registered. But the quality of those attending was on the whole superb. The scientific program, to which free scope was given for the first time, could scarcely be improved. Nor was all the good work limited to the confines of the great cities. Here and there throughout the Union earnest and capable men are taking up their residence in the smaller cities, and are doing excellent work. These men measure lances with the acknowledged leaders in the large cities and are not found wanting. It is a constant inspiration to know that as good work is being done in a certain small town in Minnesota as in the boasting Gotham, the classic Hub or the city of Brotherly Love. The man and not the place determines success or failure.

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Undoubtedly the small attendance was due to the divided condition of the profession of New York State. At least six thousand medical men belong to local societies in that state and 25 per cent of them should have been at the meeting. They were not there because there has been for a score of years a condition of society chaos in that state. This unfortunate condition of affairs we hope is in process of settlement, but many years will be required to secure a firm union of the divided surfaces.

\* \* \* \*

In pleasing contrast to this we are glad to call attention to the harmony in the ranks of the Illinois profession. Our men act together. They decide on what is the best policy and then go after it in a body. In no state in the Union is there such good feeling as in Illinois, and Chicago is more harmonious medically than any city in the country. This condition of affairs in our state was remarked by many. It was this unity of purpose which secured the admis-

sion of eight delegates from our State Society. We were clearly entitled to this number, but had there been an element of opposition in our own ranks we would have failed to secure our rights. President Harris contended that we were entitled to eight or none, and after a day of active effort eight were admitted.

\* \* \* \*

The House of Delegates proved to be a distinct success or at least a great improvement on the methods previously in vogue. A preliminary meeting patterned on those which have been held by our Society would be a valuable feature and the House will hold a short meeting of this character on the night preceding the next annual meeting. It should have been arranged to have a meeting during the entire preceding day.

\* \* \* \*

This brings up the place and time of meeting. New Orleans will be the place and the time will be early in May and previous to our next annual meeting. What shall be done regarding our delegates for this meeting? Is it of sufficient importance to have a called meeting to elect them or shall they be elected by the Illinois men attending the New Orleans meeting? New Orleans being on the southern border will probably not attract a number sufficiently large to detract from the great meeting which will be held by our Society in Chicago, which we expect to see attended by not less than 2,000 of our members.

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No feature of the meeting was of greater interest than the pathological exhibit. In this as in every other department, Illinois was well represented. We have not given up our hope that our Society would inaugurate a feature of this kind. Our next annual meeting will be a good time and place to begin it. The Chicago museums and labora-

tories contain a sufficient number of specimens to make an interesting exhibit. We hope the president can see his way clear to appoint some active worker to take hold of this matter and arrange an exhibit which will have an educational value to every member.

\* \* \* \*

Saratoga proved a good meeting place after the town was reached. The hotel accommodations were sufficient for three times the number present and the halls were fairly well adapted for the Section work. The banquets of the Sections were said to be great disappointments in every instance. Taken in connection with the failure of our last annual banquet leads us to question the advisability of keeping up these gabfests. Would not a garden party, a smoker or some other form of entertainment be a better means of getting the members together socially?

\* \* \* \*

This matter of getting our men acquainted is one which should be better planned. We are informed that the American Society of Engineers have a good system which they have employed with success for several years. On registering each member is numbered and given a badge displaying the number in large size. Then each morning a pamphlet is issued to all the members giving the name and number of each person registered. We have had it in mind to suggest that each member be given a badge which should display the name, city and state. Perhaps the numbering is a more delicate way of conveying the information, but certainly some plan should be adopted both in our State and National organizations to bring the members in closer touch. After going home we often find that persons were registered whom we should have been pleased to meet. Their faces were unknown to us and ours to them and there was no means pro-

vided to bring us together. Let us have a change.

\* \* \* \*

Probably the most gratifying event for Illinoisans at the meeting was the election of our distinguished confrere Billings to the Presidency of the Association. This distinction comes as a well merited honor to a man of great mental, moral and physical power. That he will be a success as the head of our National organization goes without saying.

\* \* \* \*

Per contra our members will regret to learn that the accomplished Secretary and Editor, Geo. H. Simmons, is in feeble health and has been ordered away for a three months' vacation. We hope that he may be soon restored to his normal condition and be able to enjoy the fruition of his past arduous labors.

#### NEW INCORPORATIONS.

The Secretary of State at Springfield has licensed the following corporations:

Red Cross Dental and Medical Association, Chicago; capital, \$10,000; to conduct a dental and medical business; incorporators, C. S. Schuermann, Oscar W. Brecher, and Sidney N. Reeve.

Ralston Chemical Company, Chicago; capital, \$1,000; to manufacture drugs and chemicals; incorporators, Isaac Pieser, Jacob G. Pieser, and Rebecca Pieser.

Jarvis G. Haley Medicine Company, Chicago; capital, \$5,000; manufacturing proprietary remedies; incorporators, Jarvis G. Haley, Sarah J. Odell, John L. Manning.

#### THE NEW CONSTITUTION AND BY-LAWS. ARTICLES OF INCORPORATION.

(Or Constitution.)

##### Article I.—Title of the Society.

The name and title of this Society shall be The Illinois State Medical Society.

##### Article II.—Object of the Society.

The object of this Society shall be to federate into one compact organization the medical profession of the State for the purpose of fostering the growth and diffusion of medical knowledge, of promoting friendly intercourse among physicians, of safe-guarding the material interests of the medical profession, of elevating and improving the standard of medical education, of securing the enactment and

enforcement of desirable medical laws, of enlightening and directing public opinion in the problems of state medicine and upon all subjects relating to state and county public charities, asylums, hospitals, and other institutions. A further object shall be to bring the medical profession of this State into close affiliation with the National Association.

#### **Article III.—Composition of the Society.**

**Section 1.** This Society shall consist of Resident, Non-Resident, Life, Honorary and Associate members.

**Section 2. Resident Members**—Resident members shall consist of all the members of all county or district societies or associations that are organized in harmony with the spirit and objects of, and which shall become branches of, the Illinois State Medical Society.

**Section 3. Non-Resident Members**—Non-Resident members shall consist of such former members of this Society and any of its branches, in good standing, as shall have become residents of other states, and who desire to retain their affiliation.

**Section 4. Life Members**—Life members shall consist of such resident members, in good standing, as shall have paid their full annual dues and all other obligations to the Society for twenty successive years, and of such worthy members as the Society may designate by unanimous vote. They shall receive the Journal of the Society and enjoy all the privileges of resident members, but shall be exempt from payment of the annual dues.

**Section 5. Honorary Members**—Honorary members shall consist of not more than ten physicians of other States, Territories, Island possessions or Foreign Countries who have risen to prominence in the profession of medicine, who may be elected by a nine-tenths vote of the House of Delegates at any annual meeting. They shall be entitled to all the privileges of resident members.

**Section 6. Associate Members**—Representative teachers and students of allied sciences, not physicians, may become associate members by a nine-tenths vote of the House of Delegates, at any annual meeting, and shall be entitled to the same privileges as resident members.

**Section 7.** The prerequisites for membership shall be a liberal education, according to the standard in vogue at the time of the individuals' graduation, and honorable, gentlemanly and professional conduct. School of graduation shall be no bar to membership, providing the applicant does not profess to practice any exclusive system of medicine.

**Section 8.** When members lose their good standing in the community where they reside, or when they lose their good standing or membership in their county or district societies, they shall cease to be members of this Society. Any member shall be liable to censure, suspension or expulsion for dishonorable, ungentlemanly or unprofessional conduct, or for non-payment of dues.

**Section 9.** Any county or district medical society through its President and Secretary

may make application to become a branch of the Illinois State Medical Society and upon approval of the Judicial Council the Secretary of the State Society shall issue a certificate that such society has been incorporated as a branch of the State Society.

In sparsely settled sections the physicians of two or more counties may organize into a society named by hyphenating the names of the counties concerned, and these societies shall be entitled to all the privileges of county societies until such counties have separate organization.

**Section 10.** City Societies, whose members constitute a large percentage of the physicians that belong to Medical Societies in any county, not already organized, may become the county organization for that county without sacrificing the original name, provided such society elects to do so and appropriately designates its function, as for example, The Chicago Medical Society (for Cook County).

**Section 11.** Five or more contiguous counties may combine into a district society, provided the combination include not less than fifty (50) members of the State Society. The presidents of such district societies and the president of the Chicago Medical Society (for Cook County) shall be the vice-presidents of the Illinois State Medical Society in the order of precedence determined by lot.

**Section 12. Representation of District Societies**—For purposes of representation only those members of district societies residing in counties having no county organization shall be enumerated.

#### **Article IV.**

**Section 1. Officers**—The officers of the Society shall be a President, Vice-President, as hereinafter provided, a Secretary, an Assistant Secretary, a Treasurer, an Editor of the Society's Journal, and nine Directors, who shall constitute the Judicial Council.

**Section 2.** The officers shall be elected annually, beginning their respective terms of office at the close of the meeting electing them; except the directors who shall each serve three years—three being elected each year. The Editor shall be elected by the Judicial Council. Each officer shall serve until his successor is elected and qualified.

**Section 3.** The officers of the Society and the Chairman of the Standing Committees shall be ex-officio members of the House of Delegates, but no member of the House of Delegates, excepting ex-officio members, shall be eligible for election to any of the offices mentioned in the foregoing sections of this article.

#### **Article V.**

**Section 1.** The House of Delegates shall consist of (a) one delegate from each county society or association a recognized branch of this Society, and one other delegate for each additional 75 members or major fraction thereof after the first 75. (b) Two delegates elected by each of the component scientific sections of this Society.

**Section 2.** The House of Delegates shall



elect all of the officers provided for in Article IV, excepting the Editor. It shall elect the Chairman of Standing Committees, on arrangements, on necrology, on legislation, and on medical societies, and the delegates to the American Medical Association, and to other societies apportioned nearly as possible among the various county and district branches of the State Society. It shall elect the person or persons designated to deliver general addresses before the Society in the manner provided in the By-Laws, and it shall attend to all other business of the Society excepting that of a scientific character and any other business pertaining to the individual sections.

#### Article VI.—Branches.

The House of Delegates shall have authority to provide for and to create such branch organizations as may be deemed essential to the promotion of the welfare of the medical profession.

#### Article VII.—Sections.

In order that its appropriate scientific work may be expeditiously and systematically performed, this Society shall be divided into Sections, each of which shall be devoted to the encouragement and pursuit of knowledge in one or more of the recognized branches into which the science and art of medicine are for convenience divided. The sections shall elect their own chairman and secretaries. New sections may be organized from time to time as the necessity for their existence arises, and when authorized by the House of Delegates.

#### Article VIII.—Sessions and Meetings.

The Society shall hold an Annual Session during which there shall be held daily a general meeting, which shall be open to all registered members and delegates; there shall be held daily meetings of the House of Delegates and such meetings of the sections as may be necessary to transact their business. The place and time for holding each annual session shall be determined for each next succeeding year by the House of Delegates, but unless otherwise ordered the time for convening shall be the Third Tuesday in May and the session shall continue three days, or until the business of the meeting shall be completed. Special sessions may be called by the Executive Committee.

#### Article IX.—Funds and Appropriations.

Funds for meeting its current expenses and awards from year to year may be raised in the Society by the annual dues, by voluntary contributions for specific objects, and by the profits on its publications.

Funds may be appropriated by the House of Delegates, in accordance with the articles of incorporation, for defraying the expenses of its annual meetings; for publications; for enabling standing committees to fulfill their respective duties, conduct their correspondence, and procure materials necessarily for the completion of their stated annual reports; for the encouragement of scientific investigation by

prizes and awards of merit; and for no other purpose.

#### Article X.—Referendum.

Section 1. The Society at its General Meetings shall have the right to discuss questions referred to it by the House of Delegates and it may by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates.

Section 2. The House of Delegates shall, upon a two-thirds vote of its own members present at the meeting, or upon a two-thirds vote of the Society at a general meeting, submit any question by mail in sealed envelopes, to the general membership for final vote, and if the persons voting shall comprise a majority of the members, the majority of such votes cast shall determine the question, and this vote shall be binding upon the House of Delegates.

#### Article XI.—Amendments.

The House of Delegates shall have power to amend their articles of incorporation by a three-fourths vote at any regular annual meeting.

### BY-LAWS.

#### Chapter I.—Membership.

Section 1. No resident or non-resident member shall take part in the proceedings of the Society or any of its Sections, until he has exhibited his credentials to the proper officer or committee, entered his name and address in full on the registration book, and paid his annual dues. He shall also indicate the Section to which he will officially attach himself.

Section 2. Resident and non-resident members who have complied with the foregoing regulations shall at all times be entitled to attend the General Meetings and the meetings of the Sections, and to participate in the affairs of the Society, and to receive its publications, so long as they continue to conform to its regulations.

Section 3. No individual who shall be under sentence of expulsion or suspension from a branch society (whether a directly affiliated county or district society or an indirectly affiliated local society) of which he may have been a member, or whose name shall have been dropped from the rolls of the same, shall be received as a member or shall be allowed to continue as a member of this Society until he shall have been relieved from said sentence or disability by such society; nor shall any person not a member of a local branch (affiliated medical society) be eligible to membership or be allowed to continue as a member in the Illinois State Medical Society.

Section 4. Any resident or non-resident member who shall fail to pay his annual dues for one year, unless absent from the country, shall not be entitled to the publications of the Society and may be dropped from the roll of members by the House of Delegates, after having been notified by the secretary of the forfeiture of his membership.

Section 5. Each county society shall judge of the qualification of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who is practicing, or who will agree to practice, non-sectarian medicine shall be entitled to membership. Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right of appeal to the House of Delegates.

### Chapter II.—Meetings.

Section 1. The General Meetings shall include all registered members and delegates, who shall have equal rights to participate in discussions and to vote upon pending questions. Each General Meeting shall be presided over by the President, or in his absence or disability, by one of the Vice-Presidents. Before it there shall be delivered upon the opening day of each annual session, the address by the President, whose recommendations shall thereupon go to the House of Delegates for action, and at each following meeting such addresses on scientific subjects as may be assigned to orators selected for the purpose. It shall have power to create committees or commissions for scientific work of special interest or importance, and to receive reports of the same, provided that any expense incurred in connection therewith by the Society must first be authorized by concurrent action of the House of Delegates and the Judicial Council.

Section 2. **Sections**—For the transaction of scientific business there shall at present be three Sections, viz.:

**Section One.** Including the Practice of Medicine, Medical Specialties, Materia Medica and Therapeutics.

**Section Two.** Including Surgery, Surgical Specialties and Obstetrics.

**Section Three.** Including Etiology, Pathology, Hygiene, State Medicine and Medical Jurisprudence.

An address not to exceed thirty minutes in length, pertaining in character to the subject-matter of each Section, shall be delivered in the general sessions, when so ordered by the Society.

It shall be the duty of the Chairman and Secretary of each Section to provide suitable papers and discussions for their Section, subject to instructions of the Society and the Executive Committee, and to conduct the proceedings of the Section when in session.

The Sections shall meet in rotation or separately at the same hour, as may be determined by the Executive Committee.

### Chapter III.—House of Delegates.

Section 1. The House of Delegates, as far as may be consistent with the Articles of Incorporation, shall be the legislative and fiscal body of the Society. Its meetings shall be open to the members of the Society, but, except upon

invitation of the House of Delegates, only Delegates shall have a right to participate in its proceedings.

Section 2. Each county and district branch entitled to representation shall have the privilege of sending one delegate to the House of Delegates and an additional delegate for every 75 of its resident members, or major fraction of 75, over and above the first 75.

Section 3. The House of Delegates, once in every three years, shall appoint a committee of five on reapportionment, of which the President and Secretary shall be members. It shall be the duty of this committee to examine the membership lists of all the affiliated county and district branches, and to determine therefrom the number of delegates to the State Society, to which each county or district branch shall be entitled for the ensuing three years, beginning with the annual meeting next succeeding that at which the re-apportionment is approved by the House of Delegates.

Section 4. Members of the House of Delegates shall be elected for a term of two years, and those county and district branches entitled to more than one representative are requested so to arrange such election that one-half of their delegates, as near as may be, shall be elected each year.

Section 5. In order that each county and district branch may properly provide for a full delegate representation at each session of the State Society, it shall have the authority to elect alternates, who, upon presentation of the proper credentials and their approval by the Judicial Council, shall be empowered to serve as delegates. In the absence of the regularly appointed delegate, or alternate, the resident members from that branch, who are present at that session, may select one of their number, who shall represent that branch, and provided further, that when only one resident member is present from any branch society, he may represent that society in case he is in other respects eligible to the office of delegate, subject in every case to the approval of the Judicial Council.

Section 6. No one shall serve as a member of the House of Delegates who has not been a resident member of the Illinois State Medical Society for at least two years.

Section 7. Every delegate from any county or district branch before being permitted to take part in the proceedings of the House of Delegates, must deposit with the secretary, or other designated officer or committee, a certificate signed by the president and secretary of the society from which he received his authority, stating that he has been regularly and legally elected a delegate to the Illinois State Medical Society for a definitely stated term; and the delegates from the Sections shall present credentials signed by the chairman and secretary of the Section they represent. This certificate shall be subjected to review by the Judicial Council, and all disputes as to credentials shall be investigated by the Judicial Council and determined by vote of the House of Delegates.



Section 8. The House of Delegates shall approve all memorials and resolutions of whatever character issued in the name of the Illinois State Medical Society before the same shall become effective.

Section 9. The House of Delegates shall present a summary of the proceedings to the last General Meeting of each annual session of the Society, or it shall publish the same in a bulletin to be issued each day during the annual session.

Section 10. A majority of the members composing the House of Delegates who are present at any regular or special session, shall constitute a quorum for the transaction of business.

#### Chapter IV.—Nomination and Election of Officers.

Section 1. Election of the nominating committee. Just before the close of the first meeting of the annual session of the House of Delegates shall elect a nominating committee of nine members in the following manner: Any number of nominations may be made in open meeting. All of these names shall be written on a black board where all can see them, or upon ballots for every member, and then each member shall prepare a ballot upon which he shall designate the names of nine only of those who have been nominated, for whom he wishes to vote. When the ballot has been counted the nine persons having received the highest number of votes shall be declared elected.

Section 2. Nominating Committee. It shall be the duty of this committee, after consultations with the members of the Society, to hold one or more meetings at which the assignment of the offices of the Society for the ensuing year shall be carefully considered. The committee shall then, on the morning of the last day of the annual session, report the result of its deliberations to the House of Delegates in the shape of a ticket providing one or more names for each office, excepting vice-presidents, who shall be the presidents of the district societies.

Section 3. All elections shall be by ballot. The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the morning of the last day of the annual session. Only those in attendance at the annual session at which the election occurs shall be eligible for election. The officers elected at each annual session of the Society shall be installed at the closing General Meeting.

Section 4. Members may vote for Section officers only in that Section with which, upon registration, they have declared their intention of uniting. Section officers shall be elected in a manner similar to that provided for the election of officers by the House of Delegates; however, the nominating committee for each Section shall consist of not more than three to five members.

#### Chapter V.—Duties of Officers.

Section 1. The duties of the President shall

be those usually pertaining to his office, and he shall preside over the House of Delegates. He shall also give the annual address at the session over which he presides and shall be ex-officio chairman of the Executive Committee.

Section 2. The Vice-Presidents in their order of precedence shall perform such duties as generally pertain to that office, and three of them shall be appointed to audit the Treasurer's annual report. Each of the Vice-Presidents shall supervise the local societies in his district. He shall promote local organization, and report the condition of medical organization in his district at the annual session of the State Society.

Section 3. The Secretary shall, with the aid of a stenographer, make a faithful record of the proceedings of each session; conduct the official correspondence; notify members of the sessions, officers of their election, and committees of their appointment and duties; preserve the archives of the Society; receive all matter intended for publication in the transactions, and prepare an accurate report of the session for publication in the Journal, and discharge such other duties as pertain to his office.

Section 4. The Editor shall be the General Manager of the Society's Journal, known as the Illinois State Medical Journal, subject to the direction of the Judicial Council. He shall attend to all the business connected therewith and shall personally or by his responsible assistants, carefully edit whatever is published therein. He shall make an annual report to the Judicial Council.

Section 5. The Assistant Secretary shall aid the Permanent Secretary as may be required. He shall be a resident of the place where the Society meets. He shall be a member of the Committee of Arrangements and of the Committee on Registration.

Section 6. The Treasurer shall have the custody of the funds, receive the dues of members, notify those in arrears at least twice each year, once immediately after, and once before each annual meeting; furnish an official list of members for the transactions, make an annual report which shall show the receipts and expenditures of the year ending with the day preceding the first day of the annual meeting, together with the number of members, the number in arrears, the names of those liable to suspension under Section 8, Article III, and the number dropped from the roll during the year, and shall perform such other duties as pertain to his office. He shall, with the Assistant Secretary, be a Committee on Registration. He shall give a bond for the safe-keeping of the funds and the proper discharge of his trust. He shall advise with the Editor upon financial matters connected with the Journal, shall receive all money payable to the Journal, and upon the order of the Editor shall pay all the expenses of the Journal. He shall disburse no other funds of the Society except on the written endorsement of the President and Secretary.



Section 7. The duties of the Judicial Council shall be to consider all questions of an ethical or personal character involving the rights or standing of members. Such questions shall be referred to the Council without discussion, and the decision of the Council thereon shall be reported promptly to the House of Delegates, and shall be final, it previously so ordered. It may issue statements to the public concerning public hygiene and the affairs of the medical profession. The Council shall also act as a Board of Directors for the Society's Journal and its other property, and shall also consider any other matters that may be referred to it by the Society and shall keep a permanent record of its proceedings.

#### Chapter VI.—Standing Committees.

The Standing Committees shall be:

The Executive Committee.

The Committee of Arrangements.

The Committee on Registration.

The Committee on Publication.

The Committee on Necrology.

The Committee on Legislation.

The Committee on Medical Societies.

The Committee Comitatas.

The Committee on U. S. Pharmacopoeia.

Excepting as otherwise provided, these committees shall be appointed by the retiring President, after consultation with the Vice-Presidents and Secretary of the Society.

#### Chapter VII.—Duties of Standing Committees.

Section 1. The Executive Committee shall consist of the President, the Secretary, the Assistant Secretary, the Chairman of each of the Sections and the Editor. This committee shall determine the character and scope of the scientific business and the order of the proceedings for each session, subject to any instructions of the Society or provision of the By-Laws, apportion the time as between the general meetings and the several sections, and previous to each annual session prepare a program of the scientific and other business to be followed by the Society and the Sections as nearly as practicable, which shall be issued by the Secretary.

Section 2. The Committee of Arrangements shall consist of five members, including the Assistant Secretary, who shall be chairman, and who shall appoint the associate members thereof. It shall be the duty of this committee to provide suitable accommodations for the session, under the direction of the Executive Committee, and in general to have charge of all the local and material interests of the session, not otherwise provided for. This committee may collect rental for space used for exhibits at the annual sessions, wherewith to defray the expenses of the session, but it shall not incur any pecuniary liability for the Society without the previously written approval of the Judicial Council. After paying the legitimate expenses of the session it shall cover any surplus into the general treasury.

Section 3. The Committee on Registration, consisting of the Treasurer and Assistant Secretary ex-officio, shall record the names, the

postoffice addresses, and the local societies of those members in attendance who have paid their dues for the current year. The list of names so registered shall be the official list for use of the Society during that session.

Section 4. The Committee on Publication shall consist of three members of the Judicial Council and the Editor, to be elected by the Council annually. The committee shall have discretionary power to omit from the Journal any paper, address or discussion, or any part thereof, on account of its length or want of preparation, or of a failure to receive a copy or proof promptly.

Section 5. The Committee on Necrology, consisting of three members, shall prepare for each session suitable biographical notices of deceased members.

Section 6. The Committee on Legislation shall consist of three members, and the President ex-officio. The duties of this committee shall be to watch the course of state legislation on medical subjects, to represent the Society in securing proposed legislation, to recommend to the Society for its endorsement proper subjects for legislation, and to report the status of pending or proposed measures.

Section 7. The Committee on Medical Societies, consisting of three members, shall use means to promote a more complete organization of the profession of the state into county and district societies, and to establish reciprocal relations between them and this Society, and shall collect and report such a list and statistics of all local societies and branches of this Society as will be suitable for publication in the transactions. This list, as revised and adopted from year to year, shall serve as an official guide for all purposes of the Society or any of its officers or committees.

Section 8. The Committee Comitatas shall consist of the Committee on Legislation, with all other members of the Society who wish to meet with it. The chairman of the Committee on Legislation shall be the chairman of this committee. This committee shall meet at 10 o'clock A. M., of the day preceding the annual session of the Society and shall consider all questions of interest to the Society that may be brought before it, and its report shall be made to the House of Delegates on the first day of the annual session.

#### Chapter VII.—Duties of Standing Committees.

Section 9. The Committee on the U. S. Pharmacopoeia shall consist of three members, with the officers of the Section on Medicine ex-officio. This committee shall report annually upon such additions or changes as may be desirable in the Pharmacopoeia, and present a summary of such reports to each Decennial Pharmacopoeial Convention, together with such other observations and recommendations as may be advisable in order that the National Standard may keep abreast of medical progress, and thus be rendered more acceptable to the medical profession.

Section 10. Each and every standing committee shall make an annual report in writing to the House of Delegates.

**Chapter VIII.—Funds and Dues.**

Section 1. Funds shall be raised by the Society to accomplish the objects for which it is organized.

Section 2. The annual dues of members shall be the subscription price of the Journal, published by the Society, which shall be \$3.00. It shall be payable at the beginning of each annual session.

Section 3. No member in arrears shall be entitled to receive the Journal, or to take any part in the meetings of the Society.

Section 4. No member or committee shall incur any pecuniary liability for the Society without a vote of the House of Delegates or the previous written approval of the Judicial Council.

**Chapter IX.**

Section 1. It shall be the duty of every member desiring to present a paper to the Society to communicate with the officers of the appropriate Section and forward the title and an abstract of the same at least one month before the annual session.

Section 2. It shall be the policy of the Society to receive only those papers that have first been presented to some county or district Society, where they may have been thoroughly discussed and as a consequence of which they may have been revised; but such papers ought not to be published in full before presentation to this Society.

Section 3. No paper or address shall be printed in the transactions unless it shall have been read in full or in abstract before the Society and referred by the Society to the Committee on Publication. It is understood that when a member, present at an annual session, is obliged to leave before his paper is reached, it may be read by the Secretary and referred for publication.

Section 4. All papers accepted by the Society thereby become its property, but members may have copies of their papers or addresses published in medical journals, provided full credit is given the Illinois State Medical Society and provided the original shall have first been delivered to the Secretary at the annual session.

Section 5. Papers announced in the printed program shall have precedence over all others.

Section 6. The reading of any paper shall not exceed twenty minutes.

**Chapter X.—Miscellaneous.**

Section 1. Reputable practitioners of medicine who may be in attendance at any annual session may be extended the courtesies of the Society for that session, with the privilege of participating in the scientific proceedings, when recommended in writing by two members, and upon having received a majority vote. They shall be known as Invited Guests.

Section 2. In discussions, each speaker shall be limited to five minutes, and no one shall speak twice on the same subject without permission of the Society.

Section 3. Every member, before addressing the Society, may be required to give his

name and address, which shall be announced by the chair.

Section 4. For the transaction of business other than scientific, by the whole Society, a quorum shall consist of 25 members.

Section 5. Every member shall be registered before participating in any part of the session.

Section 6. Applying for membership and paying dues shall be held equivalent in the obligation of members, to a formal subscription to the Constitution and By-Laws.

Section 7. In discussions, a motion for the previous question must be supported by five members.

Section 8. On all questions of order not provided for by these regulations, Roberts' Manual shall be the guide.

Section 9. These By-Laws may be suspended or changed at any annual session by a three-fourths vote of the members of the House of Delegates who are present at the session.

E. Fletcher Ingals, Chairman,  
G. W. Webster, Chicago.  
R. H. Babcock, Chicago.  
C. B. Horrell, Chicago.  
E. E. Clark, Danville.

Committee.

Dr. Ingals offered the following resolution, which was adopted, and likewise recommended to the Society for adoption:

Resolved, That for this year the Nominating Committee be constituted as heretofore; that the electoral power of the House of Delegates be delegated to the Nominating Committee, and that the other business of the Society be transacted as heretofore.

The committee offered the following suggestion, which, upon motion duly seconded, was unanimously adopted by the Society. Suggested that for the coming year the following shall be the district societies and their presidents shall be the vice-presidents of the Illinois State Medical Society:

Aesculapian Society (president must be a resident of Illinois).  
Brainerd District Society.  
District Medical Society of Central Illinois.  
Fox River Valley Medical Society.  
Military Tract Medical Society.  
North Central District Medical Society.  
Southern Illinois Medical Society.  
The Chicago Medical Society.

### Local Societies.

The Vermilion County Medical Society met the evening of the 9th. Called to order by the president. Minutes of May meeting read and adopted.

The board of censors reported favorably on the name J. M. Wilkins of Fairmount, followed by his election to membership.

The paper of the evening was by T. E. Walton on **Fistula in Ano**. Discussion opened by

H. W. Morehouse, which became general; closed by essayist.

H. W. Morehouse presented a case of **Volkman's or Ischaemic Paralysis**, also read a paper on this interesting subject.

Following was a report of the Quincy meeting.

There being no further business the society adjourned for a three months' vacation or until the regular October meeting.

E. E. Clark,  
Official Reporter.

**The Physicians' Club of Chicago** held its annual meeting May 6, 1902. The following are the officers for the coming year:

Secretary (elected by the Club), L. Harrison Mettler. Board of directors (elected by the Club), A. C. Cotton, president of the board; Joseph Zeisler, treasurer of the board; G. Frank Lydston, W. S. Christopher, John M. Dodson, J. Clarence Webster.

Yours very truly,  
L. H. Mettler,  
Official Reporter.

#### **The Knox County Medical Society.**

Meets Third Tuesdays of April and September.

##### **Officers.**

President, L. Becker.....Knoxville  
Vice President, G. A. Longbrake....Galesburg  
Secretary, G. S. Bower.....Galesburg  
Treasurer, F. Hall.....Galesburg

##### **Members.**

Baird, Ben D., Galesburg.  
Becker, L., Knoxville.  
Bower, G. S., Galesburg.  
Framing, E. C., Galesburg.  
Giles, W. N., Wataga.  
Hall, F., Galesburg.  
Hopper, H. C., Galesburg.  
Horrell, C. B., Galesburg.  
Johnson, C. G., Galesburg.  
Knowles, G. L., Maquon.  
Longbrake, G. A., Galesburg.  
Lottridge, W. M., Galesburg.  
Maley, W. H., Galesburg.  
Matheny, R. C., Galesburg.  
Randleson, J. B., E. Galesburg.  
Regan, L. R., Galesburg.  
Simpson, W. I., Knoxville.  
Wing, E. D., Galesburg.

#### **The Mercer County Medical Society.**

##### **Officers.**

President, M. G. Reynolds.....Aledo  
Vice President, H. H. Fletcher...N. Henderson  
Secretary and Treasurer, A. N. Mackey..Aledo

##### **Members.**

Carter, C. W., Aledo.  
Fletcher, H. H., N. Henderson.  
Hainline, T. C., Seaton.  
Hamilton, J. S., Viola.  
Lytle, C. F., New Boston.  
Mackey, A. N., Aledo.  
McClannahan, V. A., Viola.  
Reynolds, M. G., Aledo.  
Willets, A. P., Keithsburg.

#### **The Johnson County Medical Society.**

Meets Second Tuesdays in January, April, July and October.

##### **Officers.**

President, J. M. C. Damron.....Vienna  
Vice President, N. J. Benson.....Vienna  
Secretary and Treasurer, T. E. McCall..Vienna

##### **Members.**

Benson, N. J., Vienna.  
Brown, A. I., Vienna.  
Cavitt, R. A., Tunnel Hill.  
Damron, J. M. C., Vienna.  
Drake, H. T., Belknap.  
Fern, W. J., Tunnel Hill.  
Fulkinson, R. M., Ozark.  
Gore, T. B., Elvira.  
Hale, R. A., Bloomfield.  
Hurst, T. J., Goreville.  
Kerley, T. B., Simpson.  
LaRue, H. D., New Burnside.  
Looney, W. A., Vienna.  
Mangum, W. R., Buncombe.  
Martin, O. P., Belknap.  
Morgan, Thos., Goreville.  
McCall, R. M., Vienna.  
McCall, T. E., Vienna.  
Rose, P. W., Simpson.  
Trigg, C. B., Simpson.  
Walker, H. W., Grantsburg.  
Whitaker, H. N., Goreville.  
Whitnel, J. L., Stonefort.  
Williams, H. O., Belknap.

**The Decatur Medical Society** met in the rooms of the Decatur Club Thursday evening, May 29, 1902, with President Will C. Wood in the chair. The minutes of the previous meeting were read and approved.

On motion it was decided to proceed with the election of officers by informal ballot; the two receiving the highest vote to be candidates on the second ballot. The officers elected were:

President, S. J. Bumstead, Decatur; vice-president, F. M. Anderson, Decatur; secretary and treasurer, Lynn M. Barnes, Decatur.

Lynn M. Barnes read a paper on **Hay Fever**, in which he presented the subject very fully. The paper was discussed by A. F. Wilhelm, M. P. Parrish and Cass Chenoweth.

E. J. Brown gave a report of the proceedings at Quincy and told of the work of the legislative committee.

A motion was made and carried that the president appoint a committee of five, of which he would be chairman, to prepare programs and appoint essayists for the year.

The president appointed M. P. Parrish, M. D. Pollock and W. A. Dixon censors. Adjourned.

C. Martin Wood,  
Official Reporter.

**The Calhoun County Medical Society** held its regular meeting May 15, 1902. The meeting was called to order by Vice-President F. C. Baecht. W. A. Skeel, J. R. Vaughn, S. Flatt, I. S. Berry, F. C. Baecht, T. O. Har-



desty, M. B. Titterington, Dr. McCally, of Brussels, and F. H. Russell, of Eldred, presented themselves for membership and were unanimously elected. At 12 M. the meeting adjourned and retired to a banquet hall that had been previously arranged and spent two hours in solid comfort in eating, smoking and listening to music by Hardin's string band. This was the most brilliant feature of the day. The session was called at 2 P. M. and two hours spent in discussion of topics of interest. D. E. Hewitt and J. D. Beatty, of Winfield, Mo., were visiting members. John Davis, a medical student of three years, was numbered with the hosts.

The society was favored by the presence and search-light expressions of Editor of Times-Herald H. M. Cornia.

F. C. Baecht was elected delegate to the State Convention, with W. A. Skeel as alternate.

There being no further business the society adjourned to meet in October, 1902.

T. O. Hardesty,

Official Reporter.

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The Douglas County Medical Society met in the K. of P. hall May 1, 1902. Drs. Pullian, Reat, Brenton, Blaine, Colyer, Matheny and Rice present. Dr. Pullian in the chair.

The minutes of the previous meeting were approved.

W. Brenton read a paper on **Rational Therapeutics**, which was interesting from start to finish. The same was discussed by Drs. Reat, Matheny and Rice.

Drs. Matheny and Colyer reported cases of **Removal of Kidney**.

Dr. Rice reported seven cases of **Smallpox**, and the same was discussed by Drs. Brenton and Colyer.

There being no further papers or case reports, the society then elected the following officers for the ensuing year:

President, J. L. Reat; vice-president, W. Brenton; secretary, W. C. Blaine; treasurer, W. E. Rice.

Delegates were appointed to the State Society. The president appointed Drs. Colyer, Pullian and Rice as censors for the ensuing year.

Drs. Matheny, Colyer and Pullian were appointed to prepare papers for the next regular meeting.

There being no further business the society adjourned to meet the first Thursday in August.

W. E. Rice

Official Reporter.

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The Chicago Pediatric Society held its annual meeting in Schiller Hall on Thursday, May 1st, the vice-president in the chair. The minutes of the April meeting were read and approved. Following the annual reports of secretary and treasurer the following officers were elected for the ensuing year: President, M. P. Hatfield; vice-president, J. W. Vander-slice; secretary and treasurer, Emma M. Moore;

trustees, I. A. Abt and Julia D. Merrill. Program: Report of 90 cases of typhoid fever by I. A. Abt. Natural Feeding of Infants, A. C. Cotton.

Emma M. Moore,

Official Reporter.

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The Jacksonville Physicians' Club held its regular meeting May 31, 1902, President A. L. Adams in the chair. Several interesting cases were reported and discussed.

The subject of the evening, **Erysipelas**, was presented in a paper by Geo. E. Baxter, outlining the course and treatment of the disease. The reader held it to be a local infection of the streptococcus erysipelatis of Fehleisen, to be treated surgically, constitutional remedies having little or no value. He placed special confidence in ichthoyol as a local dressing.

D. W. Reid raised the question as to the existence of a specific erysipelas infecting organism distant from the streptococcus pyogenes of Rosenbach, and quoted numerous more recent authorities as holding the opinion that it is impossible to differentiate between the so-called streptococcus erysipelatis of Fehleisen and the streptococcus pyogenes of Rosenbach either in their morphology or mode of growth. He held that in the opinion of most recent writers on this subject there is no specific erysipelas streptococcus, but that erysipelas is a septic inflammation, caused by the same organism that in other tissues and under different conditions would cause septicaemia of the ordinary streptococcus type.

G. Edwin Baxter reviewed some experiments recently made by Dr. Pfahler of Philadelphia, going to prove, from 98 cases examined bacteriologically, that a diplococcus somewhat resembling the gonococcus, and found on the advancing border of the infected area, is the real cause of erysipelas, the experimenter having taken the organism through the entire cycle demanded by Koch's rules. Pfahler calls attention to the fact that Fehleisen noted the uniform presence of a diplococcus upon the advancing margin, but failed to give it a casual significance.

David W. Reid,

Official Reporter.

—  
The West Chicago Medical Society.

THE VALUE OF MEDICAL SOCIETIES.

—  
Address Delivered at the First Annual Banquet by Gustavus M. Blech.

Mr. Toastmaster, Colleagues and Gentlemen:

This evening is one of the happiest in my life. This is no empty phrase. Even if fame and wealth be mine during the remainder of my existence on earth, the fact that I have been instrumental in the organization of a scientific body of this metropolis will always be considered by me as a proof that my entering the ranks of the noblest profession has been productive of some good and my career as a medical man has not been devoid of anything worth mentioning.

Our genial toastmaster has honored me with the request to reply to the toast: **The Value of Medical Societies.** Where shall I begin and where end? The scholastic training of a Webster, the philosophy of a Spencer, the depth of thought of a Spinoza, the oratory of a Demosthenes are not able to do justice to so important a topic in the few minutes allotted each speaker.

There are reputable physicians who not only keep away from medical societies, but decline to join them for trivial and often unfounded reasons. Among the reasons given are that societies are mutual admiration organizations, run by cliques in the interest of a few self-constituted specialists and incidentally leaders. Are they right?

If I embrace this opportunity to answer these gentlemen I do not merely address this audience, but speak through the windows to the practitioners of the United States in general.

Before showing that the stay-aways are in the wrong, I must relate to you an otherwise insignificant incident in my boyhood, when a pupil at a German gymnasium.

One day our professor of rhetoric offered a special reward for the best essay on a peculiar subject. I do not remember the exact title, but it related to a condition of the greatest misery of man. After the regular hours the primus of the class called an informal meeting of the prospective competitors which I dubbed a "*consilium stultorum*," for we were vainly squeezing our diminutive brain cells trying to find the greatest evil to man. One youngster who thought he was an expert in mythology, called attention to the Pandora box—sickness, loss of honor, unjust conviction and sentence to banishment were proposed by some and rejected. A comrade who showed a disposition to follow the footsteps of Bill Nye suggested a mother-in-law in the same flat, which had at least the beneficial effect of exhilarating our depressed minds. The boys dispersed without having hit on anything acceptable.

I went home and asked a friend of mine, himself a teacher of rhetoric for advice. He answered with a sarcastic smile: "When you are in trouble look to the Bible for consolation."

Was he in earnest? I decided to try, anyhow and—*mirabile dictu*, I found in the Bible what I was looking for.

After the perusal of a few pages I read how God discovered that it was not good for Adam to be alone. Although the Almighty had no license from a regularly constituted board of health he proceeded to anesthetize the man and performed the operation known as thoracoplasty and rib resection. And he must have been thoroughly aseptic for Holy Writ does not record that there followed any suppuration or wound fever, but then I do not care to advertise His skill as a surgeon out of regard for the hospital surgeons who are with us this evening, and will return to my subject.

There I found the greatest evil black on white, as if specially written for me, viz.: "To be alone." I pictured myself alone in this

world. All the beautiful cities with their palaces, theatres, armories, libraries—mine. All the mountains, valleys, rivers, ponds, lakes and oceans—mine! But though sole lord over the entire domain as far as the horizon, there was not an animate body to be seen or heard, neither the bark of a dog nor the twitter of a bird. Alone! not even a miserable cat to fondle nor the loving eyes of a faithful dog to watch you. With all the wealth of nations, a living corpse, entombed in a tomb never occupied by the greatest imperator—yet living to realize the idleness of it all. Ah, truly would I exclaim: Kingdoms for the sign of animal life!

Modesy prevents me from telling you that I carried off the first prize. To be alone is the worst thing that could happen and I must confess that one of the strongest motives which has kept me from deserting the ranks of the ethical members of our profession, when an advertisement might have stopped that furious gnawing in the stomach, which is described by physiologists as hunger, was the knowledge that I could not shake hands with my respectable confreres, and rather than lose this privilege I suffered and endured, well remembering what I have learned; *perfer ac obdura labor hic tibi proderit olim!*

The medical society therefor enables the physician to meet and become acquainted with his colleagues and he is spared the evils that go hand in hand with isolation and loneliness. If for no other reason than this, a medical society has a *raison d'être*. On the other hand some writers in medical journals, carried off by idealistic impulses, would have us believe that it is our sacred duty to belong to medical societies. This is all right in a way, but the tone of such articles reminds one of the command of the old clergy who could see damnation and perdition staring the man in the face who would stay away from divine worship. Such a tone is offensive to high minded men. Physicians as a class are too enlightened to be dictated to what to do and how to live. But they are willing to listen to common sense and instead of admonishing them to do their duty towards the profession we should try to convince them that the first thing for any man to do is to do his duty towards himself and those depending on him, and I am sure membership in one or more medical societies is one of such duties. By belonging to a medical society a physician is benefiting his own interests and aiding himself towards self-preservation, which is the first law of nature.

Under our present social system everyone not depending on public charity must have or else earn money to exist. We doctors, are just as human as are other people, and our first duty is to honorably make as good a living as possible. Mark you, I say honorably.

What is meant by it? I fear it would require a greater man than the author of the "Data of Ethics" to fully and clearly define what is "honorable" in the practice of medicine.

For our purposes it will suffice to say that, any physician is practicing honorably who does:



for his patients the best he can and who, realizing that one does not know it all, tries to perfect himself according to ability and opportunity.

The recent graduate has stopped suckling the milk of wisdom from the breasts of his professors, but he is not yet developed to full manhood.

Let him shut himself out from association with more experienced confreres and the process of development will necessarily be retarded. True, a good deal of knowledge can be acquired by way of reading and personal clinical experience. Reading cannot be underrated, and he who does not read will soon become a backnumber, but after all reading acquaints one with certain ideas from one standpoint. Happy is the man who commands large clinical material, but here too one is apt to fall into errors and to be dominated by a certain amount of empiricism.

The medical society has the advantages of both with the disadvantages of none. It is the medium par excellence for our own instruction and perfection. Here ideas make deeper and more lasting impressions on our minds because we receive them *viva voce*. And when a certain theory or idea is false, there are plenty of friends on hand ready to combat and overthrow it. A mental tournament takes place in the meeting room; a trial between two opposing parties, sometimes friendly, sometimes bitterly contested, unfolds itself in all its attractiveness before the audience, who are judges and jury. And if one is so inclined one can change the role from a silent listener to attorney for either side, or develop new phases.

It is in the medical society that we learn and teach and in which we can profit by the experience of others and find food for thought and reflection.

But aside from the scientific value, there is not a society in existence, be it ever so small, where we cannot find noble and good men, a closer association with whom can but inspire us to become better and nobler ourselves!

I have seen physicians spend their evenings with laymen playing at cards or paying social visits. I do not presume to tell my confreres that it is beneath their dignity to associate with laymen. On the contrary, every physician should cultivate the friendship and respect of every good man, but I can also not refrain from warning particularly the younger members of our profession that familiarity breeds contempt and that by joining lay clubs where almost anybody can join they may occasionally secure a patient, but this patient will never have that degree of confidence in him, nor treat him with that amount of respect that he would feel for the practitioner whom he cannot call "brother" in the lodge room or with whom he has not come in contact on an equal footing. Physicians are mental aristocrats and should associate socially only with their equals, if not superiors, never with their inferiors. Again, in a medical society all fear of association with un-

worthy individuals is dispelled. A medical man can enjoy the companionship of another medical man without loss of prestige and self respect. In union there is strength. You know the story of the dying farmer, who in order to warn his seven sons that they could resist their enemies only by united action, took seven sticks, tied them together and asked each son to break the bundle. The sons could not do it. The farmer then took out each stick singly and easily broke them separately.

Our legal status is far from desirable. We have many enemies working against us and unless we stand united we will never secure suitable legislation granting us the rights and privileges we are justly entitled to.

I have heard it said when I used this argument to convince the stay-aways that they are wrong, that the law of the survival of the fittest holds good among medical men as elsewhere and that the public know a good doctor when they see one. But the fickle public is like a lot of helpless children who cannot reason. Give them some candy and they call you uncle. Give them some sugar coated pills of a millionth dilution of some drug, harmless even in ounce doses and they will advertise you as one who has saved life. Give them a little talk about "never mind" and "no matter" and they flock to you as is proven by mother Eddy. In our own city Elijah II, who, I predict, will soon weary of that title and some day discover that he is Christ if not God himself, has more followers who swear by him than the greatest pathologist or surgeon in our days.

Children should not be allowed to play with razors and fire. No sensible parent will permit that. All this class legislation twaddle is the outcry of a few fellows whose business interests are at stake. We are the guardians of the people's interests as regards their physical welfare and health and we must exert our influence and not allow a few rascals to kidnap the children alias the public. One man cannot do it, but a united profession can.

I have so far pointed out the value of medical societies in general. A great deal more can be said on the subject, but I see that our toastmaster, who, you should know, is always a scientist and who, I observe, has even on this occasion been unable to resist the temptation of experimenting on the physiological effects of the sparkling liquid, which reminds me of water because it is so different, and who is looking at his watch, which is a gentle but plain hint to stop—I mean my speech not the drinking of wine, and I will therefore conclude.

It is possible that in some larger societies the conditions first alluded to exist. What of it? Staying away will not remedy an evil. If all the members of a society wish to see equal rights given all they can easily have it.

I am glad to say that in the West Chicago Medical Society an equal opportunity is afforded every member and who ever desires to speak is given a respectful hearing.

Another trouble is that some physicians



think they are doing all that is necessary by simply paying their dues and showing themselves occasionally at a meeting. Only by an active interest in the proceedings can good fruit be borne.

On the west side of this great city physicians have heretofore passed each other with scarcely a nod of recognition. Today we have a number of good men enjoying good fellowship and as we come to know each other we cultivate mutual respect. We know now who is a good man and ere long in our immediate vicinity a membership certificate from this society will mean an "O. K." for the owner indeed.

That this society may always remain in good health is my wish (though it is already too strong to perish) and in this sense I raise my glass to a hearty *vivat, floreat, crescat!*

The Physicians' Club of Chicago held its regular monthly dinner at De Jonghe's cafe upon the evening of April 28, 1902. Dr. C. S. Bacon acted as toastmaster and the topic "What Constitutes Proper Advertising for a Physician?" was considered. The regular speakers upon the program were Drs. F. Kreissl, J. E. Stubbs, J. W. Walker and John L. Porter. An animated discussion followed in which a large number of the members of the club took part. (For the remarks of the regular speakers see elsewhere.) Mr. Shirley of the advertising department of Swift & Company, a guest of the Club, opened the general discussion. He presented the subject entirely from the layman's point of view. He said that the largest amount of loathsome and offensive advertisements put forth were those that had something to do with medical quackery. As a layman he could well understand how in some respects a medical man could not advertise himself, nevertheless it seemed to him that in some quarters the lines were drawn unnecessarily tight. Advertising is the very life of business, and as medicine is in a way a source of income, and thus has a certain business character about it, he could not see how all advertising could be dispensed with. Hence the advertising of one's self is to a certain extent absolutely necessary to the practicing physician. The question to be settled is, What is proper and what is improper advertising? Here there is a wide latitude for difference of opinion. What seems undignified and entirely unprofessional may honestly not appear so to another. Self-glorification and loud tooting of one's own personal abilities is of course offensive in itself, and it is in this way probably that the quacks offend most seriously. But there are ways of advertising one's self as a qualified professional man that is quite devoid of any repulsive ostentation or self-glorification. The speaker then suggested such care in the fitting up of one's office, the use of neat stationery, attention to one's personal appearance, the taking part in social, political and church life, the cultivation of attractive manners, the use of the latest and newest appa-

ratus for physical examination as all powerful means of individualizing one's self and calling the attention of the laity to one's special qualifications. As for putting a card in the daily paper he was not prepared to say what he thought might be proper, though he believed that a little more freedom in this respect than is usually exercised would not be undignified and unprofessional. However, that is a matter for the profession as a body to decide and cannot be settled by the mere expression of individual opinion.

Joseph Zeisler said that though the discussion of this topic would not lead to any great reforms, the constant agitation of the question was good in that it defined within certain limits what is proper, and in this way probably prevented gross breaches of etiquette. After all the question is largely a personal one, just as the question of religion is. We can all talk about it, but we will all go home and do what our good sense dictates regardless of what others may think. It is after all a question of a man's personality. Of course a doctor has got to make himself known. He cannot go off in some corner of his village, put up his sign and trust in Providence to bring him a patient. He must make it known that he is there and that he is qualified. That means advertising. The question then is what is dignified and professional. The personal characteristics of the man, his innate gentlemanliness or boorishness will settle that. The speaker then referred to various methods of advertising that are considered legitimate. For instance, the reprint. He knew of a certain man of large renown who sent 10,000 reprints all over the country, in which the scientific matter was puerile and absolutely without value. He himself believed that the use of the reprint was much overdone. It seemed to him that a few of these sent to one's personal friends is all that should be considered in good taste. As for himself he had been most unskillful (!) in getting his name into the public press when he compared himself with what some of his conferees were doing. He disliked anything like personal publicity and for a doctor generally he believed it was not only in very bad taste but in most respects it was decidedly unprofitable.

D. O. Hecht referred to the fact very largely that the question was a very vital one to the young and struggling physician. He was sorry to see that certain newspaper notices and reports of operations were not frowned upon so darkly when one of the older and more distinguished members of the profession was the subject of the notice. As a young man himself, however, he had come to learn and not to presume to give opinions, hence he begged to be excused from saying anything more specific in connection with the topic.

H. R. Pusey, in a very happy vein, gave vent to some laughable personalities and witticisms and finally ended by stating that he believed a greater latitude in regard to press

notices was allowable than is sometimes suggested. The young man must make himself known, and if the eminent surgeon is allowed the privilege of press notices he could not see why the same privilege should not be granted to the younger and less known man. Dignity and good taste, as a rule, will regulate all such matters and he was glad the subject had been so thoroughly treated by the principal speaker of the evening.

Denslow Lewis argued in favor of more freedom in the doctor appearing in the public press. Like Dr. Pusey, he believed that it was in perfect good taste for a doctor, when asked, to contribute a plainly worded, scientific article for the newspaper. Such an article when signed without the physician giving his address, office hours and other things suggestive of a personal advertisement, was not only allowable but was now and then absolutely necessary to educate the people away from quackery. How were the people to learn of medical matters, the dangers of venereal disease, for instance, if they are not told of them. And how are they to be told of them if they are not presented in the periodicals which they read. Much of the rampant quackery and isms of the present time is due to the foolish conservatism of the profession which goes to such extreme as to forbid the use of popular periodicals as a means of instructing the laity on matters medical. The personal advertisement that seems to be attached to the publication of such articles is of little significance in comparison with the great good thus obtained in educating the public and suppressing quackery.

William H. Wilder argued that it was not the province of the lay press to educate the public on matters of a technical sort. The value of such articles would be nullified by their extreme simplicity and might thus even give rise to false notions. This education of the laity on scientific subjects by means of so-called popular articles he believed to be quite useless for it did not result in much education, as the laity do not read such articles with much eagerness in the newspapers and the attempt to instill such education by such means seemed to him to have more of the character of an effort at personal advertisement. He therefore believed that if such articles are needed, they should be unsigned like the editorials, or signed at least only by the author's initials. He believed all pictures and notices and signed articles from the pens of physicians and appearing in the daily press are highly undignified and unprofessional. The whole question is not so much one of ethics for it is not a crime, but one of good taste and etiquette. He then spoke of the customs among the best men in England, where they have no code of ethics, but where all such matters are rigidly regulated by a high *esprit de corps*.

J. W. Pettit, of Ottawa, Ill., said he differed very strongly with Dr. Wilder. He believed that heretofore the profession has kept itself too exclusive; as a result the people have

been left to be educated by the misstatements and pretensions of the quacks. Having had much experience in medical legislation he knew that the ignorance of the average legislator in regard to medical matters was a large stumbling block towards preventing desirable legislation. We are almost hypocritical as a profession in some of our ethical pretensions. We blame the people for not knowing more about what we are doing and yet we fear to use the very means by which we can best instruct them. The way to attack an evil is not to fold our hands and walk away from it, but to grapple with it itself. If the public press were used more freely by the reputable men of the profession, the laity would soon become so well informed on medical matters that the quacks would disappear from want of a following. The doctor should be a citizen and public spirited man. His opportunities and training put him in a position to do splendid work in suppressing superstition and ignorant credibility; but he will not be able to accomplish much by a policy which adopts as its motto I-am-better-than-thou and therefore cannot have anything to do with you. The profession is too strong, too noble, too influential to occupy so exclusive a position from fear of self-contamination. It should use every means to advance learning and the cause of right and not the least among those means is the great daily press of the country.

L. H. Mettler stated that the speakers had wandered a little from the topic. The question was one of advertising. Advertising had for its ultimate purpose the increase of one's revenue; hence the whole question comes down to that of the pocketbook. Does it pay and what sort of advertising does not pay? That is the gist of the matter aside from its aesthetic consideration, which latter is a matter solely of personal taste. There is an itching on the part of many men to appear in the newspaper. Would they care a continental about it if they thought that such publicity did not enhance their incomes? The speaker said he thought not. Hence newspaper publicity is or is not profitable. In the speaker's judgment he could not see how it could be profitable unless the notices were frequent and continuous for nothing is so ephemeral as newspaper notoriety. But constant newspaper notoriety condemns a man at once as having bad taste for it is like the notices in the society columns, which are not objectionable if infrequent, but are most distasteful to the better class of people if overdone. As for the doctor appearing as an occasional writer upon medical topics in the daily press, the speaker saw nothing to condemn it but much to favor it. If a well-known banker or merchant is asked to discuss his specialty in the press nobody feels that he has lost caste, but the moment a man puts M. D. after his name, at once he must go into seclusion and not appear in the same public spirited light that his neighbors and fellow-citizens appear. That is ridiculous and has done much harm to the



profession. Moreover, there is much cant voiced in regard to the so-called tricks of advertising. If a man has the means and taste to occupy a box at the opera, drive a fine team of horses, give dinners to his friends and hold a forward pew in a fashionable church, there are those who put it down as advertising, if this man happens to be a doctor, though no such ideas are intimated if he happens to be a banker or a merchant. Let us have done with such hypocritical cant and let us give to the doctor the same honor and privilege that we grant to any other honest and straightforward citizen. Advertising is largely a personal question after all. If it is done vulgarly and with the sole purpose of getting lucre, let it be condemned and let the doer be ostracized though he be the leading light in the profession. But on the other hand, if he do things of a semi-public character, such as any other citizen is entitled to do, let us not say he is doing it to advertise himself for the sake of lucre, even though he be the least known member of the profession.

Walter M. Fitch spoke of the necessity of legitimate advertising and said that within the code of ethics there was much latitude and difference of opinion. He believed it was largely a personal question after all and that a man would gain or lose by it according to the taste that he possessed. He saw no harm in newspaper articles when written by well-known men upon topics of public interest.

C. W. Courtwright entertained the Club with a number of stories bearing upon the topic of medical advertising and concluded by saying that he was glad to see that the hard conservatism of the profession was being broken into and that it was coming around to a more liberal and public spirited way of looking at things.

L. Harrison Mettler,  
Official Reporter.

#### WHAT CONSTITUTES PROPER ADVERTISING FOR THE PHYSICIAN?

By F. Kreissl.

I accepted with reluctance the honor of taking part in the discussion of this subject on the program. While I knew very well what constitutes improper advertisement, I felt that I would rather like someone to tell me how to advertise without trespassing on the code of professional ethics. After giving the subject some thought, having consulted several colleagues who also professed ignorance, but ventilated their grievances against the guilty ones, and after refreshing my memory of what I have seen, read and heard in eighteen years of practice here and abroad, I have formulated some ideas as to how professional advertisement is done, and how it ought to be done. Of course, my remarks are exclusively based on personal observations limited to two cities, and I do not expect to see them accepted as a guide for anyone in his future policy regarding this subject.

By raising the question, "What Constitutes Proper Advertising for a Physician?" it is conceded that advertising within certain limits is permitted, perhaps even necessary to the success of the professional man. By this admission, it is also evident that we do not any more consider the medical man as belonging to an exclusive class, enjoying special privileges and distinction, but as a man engaged in his vocation like every other mortal business man. We may still believe our work to be more ideal than that of a manufacturer or distributor of merchandise, while the merchant, banker or millionaire packer considers himself the real benefactor of the human race. Now, who are the men who are chiefly interested in this subject? I think the gentlemen engaged in specialties. At least, it seems so, judging by the fact that I never heard a physician advertise that he makes a specialty of general practice, and, furthermore, because most of the complaints of real or imagined improper advertisement are lodged against specialists. Quite frequently the complainant is also a specialist. For this reason, and not out of disregard for the much-burdened and yet most-enduring practitioner, my remarks do not refer to him so extensively.

The young practitioner starts from conditions quite different from those under which the trained specialist is supposed to begin his career. If he has more brains than money, this being the rule, he settles down in the thickly populated districts of the big cities. His first patrons usually are former schoolmates, old acquaintances of the fraternity, or the base or football battle grounds. They have known him for years; they have listened to his gresome stories from the dissecting and operating room while he was a student, and their respect for his skill and ability increased with the amount of scientific medical terms at his command. Consequently he is the first man they consult when ailing from the results of indiscretions and folly. His relatives, elated because of the young man's early success, tell their friends and neighbors, in confidence, of his wonderful ability, and soon he is a little local celebrity within the radius of a few square blocks. The nearby druggist, there is always a druggist near by, has filled a few of his prescriptions, and, grateful, like all druggists, he tells everybody of the great future the young physician has. A woman whom the druggist has failed to cure of dyspepsia, is sent to him, and his diagnosis, anemia, proves correct by the successful administration of peptomangan of iron. She has another friend who has just made up her mind to consult Dr. Dowie, having found no relief from sick spells by Dr. Bunions, free physicians, who sold her tape-worm remedies. Our young friend diagnoses quite correctly a third month pregnancy, and it is but natural that he is retained to take charge of the confinement. And in this and similar ways he gradually gains in well-deserved reputation, in the number of patients, and in his income. His expenses are com-



partively small, and, looking back over a short period of success, he can confidently trust to the future for a good, permanent and remunerative family practice.

An entirely different proposition confronts the specialist who, as is the rule, has devoted a number of years and spent a good deal of money in preparing himself for his work, meanwhile earning nothing. An exception are the cases in which the specialist has practiced for a time before and while making special studies in one line of medicine or surgery. The specialist needs for his work an especially adapted office, many expensive instruments and appliances, and quite frequently, also a paid assistant. He is not always the possessor of a rich father or father-in-law, an incident which would allow him to walk in the narrow path of professional dignity and virtue, without a slip or stumble. He easily could afford to wait patiently until some day he might reach the goal through one or the other of the customary channels. But, notwithstanding the financial reasons, there is a certain amount of ambition and pride in every capable physician, and particularly so in the specialist. It is the desire to be recognized, and to see his labors and efforts appreciated by the profession at large. How can both ends be accomplished?

In the customary way, first, by clinical work and teaching; second, by literary efforts in medical societies and in the medical press.

Even when taking the various after-supper and midnight schools in consideration, not withstanding high grade institutions like Rush, N. W., and M. D., University of Illinois, there is yet a limit to the number of chairs obtainable, and this kind of furniture must be very expensive, because they are usually made so small that there is only room for one man to sit; sometimes a second man is or can make himself so little as to find a narrow strip on the same seat with the big man, without annoying him. The others have still a chance in some of the institutions in which the privilege and honor of a professorship is conferred upon the worthy applicant for a consideration ranging from fifty to two thousand dollars, but not everybody can afford to pay this price, even if the honor and the chance were worth much more, though sometimes payment is allowed on the installment plan. I found these conditions to exist several years ago. Have they changed since?

The eminent teacher in an accredited medical school has a standing advertisement in his students, who carry his name and his well-deserved fame all over the continent. In these high grade institutions he also has all the facilities for scientific research work in associated hospitals; supported by capable assistants he gathers all new ideas and developments and publishes the results of his efforts in textbooks, monographies, or original contributions in the medical press and in society meetings. All these give testimony for the skill of the man and naturally form a perpetual advertisement on the desk of the reader.

But the extra territorial specialist, as I would call him, the man who has the same ambitions, the same capability without the opportunities and facilities of such a valuable piece of furniture like a chair has nothing but his more or less grateful patients to satisfy his pecuniary appetite and his ambitious thirst. With a limited material the chances for effective research work are slim, consequently the possibility of making himself known to the profession by original, practical or literary publications is greatly reduced, and with it the support from the profession. Here the extra territorial specialist is at a great disadvantage compared with the general practitioner who has a perpetual resource in his family practice. While there is always some sickness in a family the specialist is rarely put in a position to treat the same patient for the same ailment twice or oftener. The human race now-a-days has still but one vermiform appendix, one uterus and but two ovaries and tubes, and the cases of a supernumerary kidney are much rarer than those of only one kidney. I have not heard of more than two mastoid operations on the same person, and but one total extirpation of the stomach.

Having no other resources it is but natural that this man if not of Catonian principles tries to break through the high fence, separating him from reaching the profession or that he wishes to inform the laity that he is also a capable specialist. To this end he leaves, as some would call it, the path of professional dignity and virtue. He perpetrates the horrible crime of telling physicians and patients in the daily press that he makes a specialty of treating certain diseases, and in this way he becomes an ostracized outcast. Meanwhile there is not everything gold that glitters, and some of the chair holding teachers are pressed just as hard, if not harder, than the extra territorial man. The conditions today are different from what they were twenty-five years ago. At that time there were but a few centers of medical teaching, very few eminent teachers, the large cities smaller, the number of medical journals fewer. It took less efforts and time to become well known and recognized as a leading physician or surgeon, and a great many students gathered around a single teacher, who commanded a proportionately large clinical material. Today there are schools which can boast of more professors than students. The material is scattered in the many smaller institutions, the population has increased so much that it takes years and years to become recognized as a leader. The medical newspapers have increased in number, the readers in proportion decreased, the facilities of obtaining a good medical and surgical education are greater, consequently the number of competent men increased and the competition keener, and some of these very best men would gladly do what the extra territorial specialist does if they could only gather enough courage for the high dive.

Out of the lowlands of medical science another element has been created of late years, partly due to this anomalous condition. It is the semi-specialist, and the baby specialist. The first knows something, and thinks he knows more than anybody and wishes all the others to believe it. The other knows he knows nothing, but as soon as he gets his diploma he thinks he can make all the others believe what the first one imagines of himself. These are the men who attempt to run medical societies, who discourage honest and good work and keep the better elements away in disgust. They will never stoop so low as the extra territorial specialist, although one or the other of this honorable bunch might occasionally buy a half interest as a silent partner in the Cosmopolitan Medical Institute on Balsted street, or hire himself out to the famous Dr. Richardson, or Dr. Kingston Hanna, late from Edinburg, Eng., or demand the division of a fee, when the attempt for a loan has failed. But in this millieaux they represent the medical pirates. Their motto is, "Keep your name constantly before the profession." Write "many," even if you don't write "much"; clip and steal where you see a door open, give the old coat a new trimming and buttons, and sell it as brand new, and before all never fail to wind up your publications with the standard phrase like this: I do urethroscope of the lachrimal duct, I am the only one who does vaginal hysterectomy by my new method through the rectum, I perform mastoid operations through the pharynx with my new improved instrument a. s. f.

Occasionally they make a big bluff of a stand if any one dares to disagree with them, but generally they care very little for criticism. They play their game on the country practitioner, whom they presume not to be in very close touch with the current literature. The thousands of reprints of this original hold-up work having obtained the stamp of approval of respectable societies under false pretences are dished out to the guileless country practitioner, weekly or monthly until he is made believe this Dr. Foolisher, Dr. Underall, Dr. Kidd, Dr. Roliger to be a wonder, a genius. But this is all perfectly straight and legitimate, because it is done through the official medical papers and not in the daily press. If you wish to criticise it very harshly you can only call it poor art but good politics, but there is no impropriety in it. Certainly not. But if a recognized leader in medicine who is too well known to need advertisement writes "belletristic" articles for a daily journal, a flutter of excitement and indignation runs through many of our profession. It is considered a serious breach of etiquette, a disgraceful way of advertising which should not be tolerated. Why! in accepting his diploma has he also taken the veil and the vows, promising to be dead for the general reading public, and to devote all his thoughts to the sacred cause of Aesculapius only? Or is it a crime if a professional man interviewed on medical topics of general interest gives his

views to the public? I believe he owes it to the public and it makes no difference whether such statements appear two hours before or after they have been communicated to the profession, as long as the author and those who side with him show the same liberal interpretation in judging similar procedures of others. If Dr. Baight has discovered a new method of removing a steel factory from the eustachian tube, or if he is the first one who ever did it, and nobody else can do it, why the public suffering from such injuries is entitled to be informed to whom to apply for relief. But if the removal of such a steel factory is a surgical feature, done by others before, even so requiring great skill, I consider the publication of such a case in the daily press improper advertisement, provided the surgeon had his hands in it. I also fail to see anything wrong or dishonest or improper if under the present conditions a capable man deprived of all other means to make himself known tells the reader of the daily press what he is ready and able to cure. Contrary, I respect the man provided he is honest and lives up to what he promises. I certainly admire him much more than the honorable semi and baby specialist and the man who does not advertise, but refuses to call in consultation the other men whom he knows to be competent, but whom he is afraid to advertise by doing so, or the man who tips elevator men, hotel clerks, and head waiters for sending him patients belonging to others, while he shows great indignation when such topics are discussed in societies.

Altogether I predict that the time is not so far, where a great many good specialists who have not the advantage of other more fortunate ones, will be forced to apply to the public in the daily press, and by doing so they will crowd out of business the advertising quack and faker.

Summing up the situation it seems to me it is a tempest in the teapot. The educated man, the gentlemen in our profession, and those are the vast majority, will always be gentlemen irrespective if, or where, he advertises. The hog, irrespective of attempted legislation and education will always be a hog, even in a full dress coat and with gloves on. At best you will make him an educated hog, but still a hog.

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#### WHAT CONSTITUTES PROPER ADVERTISING FOR A PHYSICIAN

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By James W. Walker, Chicago.

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While the word advertising when applied to physicians usually carries with it the suggestion of mercantile methods adapted to professional pursuits. It would be altogether too sweeping and nihilistic a statement to say that advertising must be absolutely tabooed. In saying this I employ the verb in its restricted sense of meaning, to inform or to make known. We must advertise, the question being how may we do it legitimately? There cannot possibly be anyone here who approves



the commercial methods adopted by some who are regular graduates, and in good legal standing, but there must be a happy medium between this extreme and that of the timid graduate who, emerging from college or hospital, retires within his ethical shell in some unfrequented place, fatuously expecting a waiting world to discover him. Wherein, then, lies this happy medium? To begin, our advertiser should send his class graduation notice and invitation to every one of his friends, and if he has graduated with honors or hospital appointment, he owes it to his immediate friends to let them know the bare facts, and these friends will do the rest. During his hospital career he may inform such as are interested in knowing when and where he expects to locate, and what line of work he will pursue. It is not necessary that his picture appear in the newspapers during his internship, as is the present vogue.

The statement may properly appear among the personal items of his local medical journal, if he go abroad to study. If for rest and recreation, it should be so stated. Letters to his college or medical papers, giving medical and surgical news from abroad, will properly advertise him and help others. On locating, he should send to all of his lay and professional friends his card, engraved rather than printed, bearing his name, address, office hours and telephone number, and line of special practice, should he have made the mistake of limiting himself thus early. His name should be distinctive and unalterable, not J. F. Jones one day, John F. Jones another, and J. Frank Jones another. He thus lays the foundation for an individuality.

His office and furnishings should be the best that he can afford; his equipment likewise. It is fatal advertising not to have a stomach tube when called to a poison case, and no apologies will atone for a leaking hypodermic to one suffering with gall stone colic. His armamentarium should be equal to all ordinary emergencies, and whether exhibited in a glass case or hidden away in a cupboard will depend upon the personality of the man. But he may with entire propriety let it be known to his own patients that he has a good stock of instruments, and laboratory facilities.

A neat and modest door or window-plate should be displayed, and to the red lamp of the English physician as a guide by night no valid objections can be made. He will do well to refrain from adding his shingle to the creaking accumulations of neighboring drug stores, and should he occupy a down-town office, his superfluous gold can be better invested than by smearing it over his office window.

I see no objection to his displaying in his office his college and hospital diplomas or state certificate, especially while new to a neighborhood.

The young man, on locating, can, without any sacrifice of modesty, call upon his neighboring colleagues, and volunteer his services in anesthetizing, counting blood, examining

urine, looking up literature, or taking care of charity cases.

His personal appearance should be above criticism. Many a physician has won his way to success because "he is always so neat and clean, don't you know?" while a dirty collar or dirty finger-nails has secured many a capable man an immunity from a second call. Robert Herrick says that slovenliness is the besetting sin of the century. It is also bad advertising for physicians, whatever it may be for musicians and artists.

Hospital and college appointments constitute proper advertising, though the multiplicity of them renders them less valuable for this purpose than formerly. Faithful attendance at medical society meetings, and participation in discussion is legitimate and good advertising for many, some are better advertised by staying away. The generous mailing of reprints of published articles serves to make the writer widely known, and nothing can be said against the custom. Bills should be sent out with regularity, and checks acknowledged promptly. Carelessness about collecting is unjust alike to patient, physician and profession, and advertises the man as lacking system and method.

Attendance at political, religious and social functions enlarges one's circle of friends, and gives the laity some opportunity to become acquainted with the personal characteristics of those upon whom they will become dependent when visited by sickness. With full propriety the physician may devote some of his time to lecturing or reading papers to societies of laymen on such medical topics as they can understand, and in writing for lay journals, efficiently advertising himself and discharging a much-neglected duty on the part of the profession. I do not regard it as improper for the physician to discuss with his own patients such medical subjects as come within the sphere of their understanding. If he knows his subject, their opinion of him will be enhanced thereby. If he doesn't, they will have an opportunity of discovering it. A cutting away of much of the mysticism connected with medicine would materially discourage the various forms of pseudo-healing and advertise the claims of rational practice.

Every mark of confidence bestowed upon the physician by a college, a society, or discerning individual he may be permitted to use in a quiet, unostentatious manner, to strengthen his prestige with his own patients. They are as much entitled to know this as to know that the particular brand of pickles they enjoy has secured an exposition medal.

The usual advertisement of the country doctor in his village newspaper is probably as harmless as it is useless.

The methods of the specialist will differ somewhat from those of the practitioner. Amongst other things, he cannot afford to neglect acknowledging cases from the general practitioner, together with a brief note reporting progress from time to time; nor must



he forget to refer them back to the sender when through with them. To the specialist, attendance at medical meetings, college appointments and the publishing of papers is a *sine qua non* of success.

What constitutes improper advertising? In the first place, we must not deceive. When in doubt, let us apply the golden rule. Let us become patients for the time-being, and ask, How would we have our physical adviser behave? We can smile if all the newspapers claim the largest circulation, but let not any one of us have more cases of diphtheria in a month than the city returns show. Let us not be rushed to death with work when in truth we are far from busy. Of the threadbare devices of driving furiously to nowhere in particular, or of being called out of church, we need hardly speak, though I believe a few physicians still go to church. Let us not, with a shrug of the shoulders, and an eloquent silence, cast doubt on the ability of our colleague, nor fill his trusting patient with stories of our successes, however truthful they may be. Let us exercise a fine discrimination about giving interviews to newspapers, remembering that they are much more concerned about selling papers than about enlightening the public. Let us not obtrude medical topics into general conversation, but wait for invitations, nor discuss our cases except with our trustworthy colleagues, nor gossip about our neighbor's treatment of the last case he lost. Everything about us and everything we do should be characterized by a sense of refinement and good taste, and forgetting that the chief aim of the art of healing is thus better subserved than by introducing the distracting and doubtful methods of the market-place.

It may be observed that none of the advertising methods sanctioned here are such as may not be indulged in by anyone not having a spark of commercialism in his nature, but imbued solely by an honest desire to do well his chosen work; the one inclusive fruitful and proper method of advertising, then, is sincere, unremitting toil. It needs no fanfare of trumpets to herald it; those who have benefited by it will carry the news, if not so speedily, none the less surely. Competition we cannot eradicate, nor should we try; it is necessary to progress, but it should consist in improving the standard of our efficiency, rather than by striving by noisy means to take from our colleague that to which his rights are equal, if not greater, than our own. Every act of aggressive advertising not in consonance with dignity of behavior will provoke competitors to copying, and the second condition will be worse than the first. The tendency in America is unfortunately in the wrong direction, and we are in need of more examples of the sturdy independence of one we have recently mourned, who scorned all the petty tricks unworthy his high calling. Either let us stand apart and declare ourselves commercial doctors, filling the hoardings and newspapers with our blatant boastings, or let us behave like men, truly gentle, compelling

the respect of the public for a profession second to none in unselfishness, in dignity, and in nobility.

### "WHAT CONSTITUTES PROPER ADVERTISING FOR THE PHYSICIAN?"

By John L. Porter.

Mr. President and Members of the Physicians' Club:

I am glad that the chairman in calling upon me has made the explanation that he has, for when he remarked, earlier in the evening, that he hoped to hear from the "experts" on this subject, I felt that I should request to be excepted from that class.

I am here this evening purely for information—certainly not to impart any. One phase of this question I had particularly hoped would be discussed as I have long been wishing for an explanation of the matter.

I think if I had arranged the question for discussion this evening I should have asked "What Constitutes Proper Advertising for a Young Physician?"

The question as it now stands assumes that, so far as advertising is concerned, all physicians are equal. That is a fallacy. For we all know that what seems to be very proper advertising for older, prominent and successful specialists would be an unpardonable sin if indulged in by some young, obscure practitioner who had no reputation.

I speak from the standpoint of the younger men, for I am still a tyro in medicine compared with some of those present, and I want to ask some one to tell me why the distinction I refer to exists.

When I graduated in medicine that dear old dean and preceptor of so many of us, Dr. N. S. Davis, presented me with a copy of the Code of Ethics with the terse remark that it was worth reading. I read it. I suppose everyone does. And I started out in practice filled with a sublime belief in the honor, dignity, unselfishness and lack of commercialism of my chosen profession and all those other hackneyed expressions that sound so beautiful. I suppose most young men feel the same way. But I had not been where I could see the practical side of things more than a month before my idols began to fall, and they have kept on falling until now all I want to know about the advertising business is, What is allowable for an unknown ambitious young man who has no national nor even local fame and success to shield him?

That's the question that hasn't been answered.

But seriously, Mr. President, what happens to the beginner with the hypersensitive and exaggerated ideas of the nobleness, etc., of our profession to convert him in a few months into professional pessimist and agnostic?

Well, let me tell you.

First of all he begins with an intense admiration and respect for certain great lights

and prominent specialists in the profession. He looks up to them as professional ideals and as personal exemplars of what he may hope to obtain, and he resolves to sit awhile at the feet of the learned—to spend the time while he is waiting for a practice in getting acquainted with these great men and their methods—and he does!

First he goes to the clinic of one of the famous local surgeon whose name has been synonymous with skill and learning ever since he bought his first text-book on surgery. He has the good luck to see him perform a very unusual operation, perhaps a total gastrectomy, and the surgeon's technic and language are so brilliant and inspiring that he places him in the very highest niche in his hall of fame.

A few days later he picks up his morning paper and the first thing that meets his eye is a picture of this famous surgeon capped by such headlines as this:

#### HIS STOMACH'S GONE!

But Gus Johnson Can Eat Saurkraut and Sausage!

Dr. Blower Performs the Most Wonderful Operation of the Century!

He Removes a Diseased Stomach and Hitches the Gullet to the Bowels!

Operation Only Performed Twice Before in the History of Man and Both Patients Died.

This Patient Not Only Lives But Eats!

Had His First Square Meal Yesterday.

And then follows an account of the operation he had witnessed, in which words and phrases characteristic of the surgeon appear and even some sentences verbatim—a description which could only have been written by some one who was there. Was there a reporter present. If so, why was he present at that particular unusual operation instead of at a more commonplace occasion? If he was there unknown to the operator, why was the report of the operation “held up” until the result was assured? As the young physician asks himself these questions his first idol falls. The highest niche is empty.

About a year ago our young doctor saw a short notice in the paper that a well known specialist had been appointed to the staff of Cook County Hospital. While he was not one of the doctor's idols he knew of his reputation and congratulated the patients of Cook county that here was one man who had been appointed for his scientific ability and not from any political pull.

The next day the aforesaid specialist's picture stares at him from the morning paper followed by something like this:

“Dr. Stringem, our prominent specialist, who has just been appointed a surgeon to Cook County Hospital, is also a delegate to the

International Congress of Tuberculosis which meets in Dublin next month.

“The doctor accompanied by Mrs. Stringem sails on the red liner Henry VIII on June 3rd. After reading a paper before the Congress on “Tuberculosis of the Eye, Ear, Nose and Throat and Accessory Cavities,” the doctor will visit the clinics at Berlin, Hamburg, Paris and London to show them how, and will sail from Liverpool August 5th. He will be back in Chicago August 17th.”

This was illumined by a full size cabinet photograph of the doctor taken in full-dress. No evidence of its being a snap-shot. Query: How did the newspaper get the photograph, date of sailing, itinerary and date of return? Probably they sent a reporter to break into the house at night and get them at the point of a pistol.

About this time our tenderfoot is visited at his office by a prosperous looking man who introduces himself as the representative of a well-known publishing house. He says, “We are getting out an illustrated work entitled “Illinois: Its Chief Cities and Citizens.” We propose to publish therein an article describing each of the chief towns in the state, its industries and prominent citizens with their pictures. We shall include in our article on Chicago all the prominent business and professional men and have allotted space for about fifty physicians. I have been referred to you as one of the rising young men in the profession and would like to include your biography and photograph.”

Then he went on to describe in an insinuating way the benefits to be derived from appearing in such a publication—that the work would have a large circulation outside as well as inside the state, and would have a great many readers. Gradually it dawned upon our tenderfoot that this was an advertising scheme, pure and simple. He asked the price for appearing in the pages of the publication. The reply was “Oh, we don't charge anything for publishing the autobiography and picture but we find that nearly everyone who appears in it wants a few reprints to distribute among his friends, so we make it a rule to print one thousand reprints of each autobiography and these you would have to contract to take at the nominal price of thirty-five dollars.”

“Do you mean to say,” asks the tenderfoot, “that any reputable, regular physician in Chicago has subscribed to such a bare-faced advertising scheme as that?”

“Why certainly.” And he exhibits a list of some twenty-five who had contributed autobiographies. Among them were several members of the State Society, some were members of the Chicago Medical Society, and a few were very well known men. He declined the proposition and showed the agent the door.

Later, happening to come across the publication, he looked to see if any physicians he knew had really gone into the thing, and sure enough—a few more idols fell. There were their pictures with the laudatory autobiography, titles and professional appointments *ad nau-*



scam and even, in some instances, the social status, club memberships and civil state.

Some time ago one of our charitable institutions for the care of children was exploited in the daily press, ostensibly to open the hearts and purses of the philanthropic.

The great benefits which the children received and the wonderful operations performed were detailed with pictures of cases "before" and "after." The names of the attending surgeons were mentioned and their methods of treatment described in quasi-medical terms.

Our young novice thought he recognized the voice and peculiarities of speech of one of the surgeons mentioned in the article and later he learned that that surgeon was wholly responsible for it.

He had taken a reporter on a "personally conducted tour" through the institution and furnished the facts and pictures. Crash! Our young friend tearfully removes the fragments of another idol.

Early in his career our young tenderfoot received a program of a medical meeting to be held in a distant city.

He notices among the papers one to be read by one of the most prominent surgeons of the country, one whom he has often seen and admired—one of his idols.

The paper promises to be of unusual interest and value as the title is "Surgery in the Medical Field—The Treatment of Bright's Disease by Surgical Means—A Report of One Thousand Cases." The young man regrets that financial depression will prevent him attending the meeting and listening to the paper and forgets all about it. He forgets it—until he is again startled by his daily paper. This time he finds something like the following in almost every daily paper in Chicago: "INCURABLE DISEASE CONQUERED AT LAST."

---

"Dr. Blank, Our Famous Surgeon, Startles the National Medical Association at Cheyenne."

---

"He Describes a Method of Curing Bright's Disease by the Injection of Hot Air!"

---

And not only are the articles illustrated by the doctor's genial likeness but one enterprising daily has cuts of the region to be inflated and even of the hot-air tank used in the operation.

It occurs to the young doctor that the medical society is even now in session. He refers to the program and finds this is the second day of the meeting. He finds there were no papers to be read the previous forenoon. By a little chronological calculation he finds that if the paper had been read on the previous afternoon—allowing for the difference in local time, the newspapers would have had just two hours to get the report from Cheyenne, hunt up the doctor's photograph, get out the new cuts and get it into press.

As the young man sadly smashes his last idol it occurs to him that if that article was not furnished to the newspapers before it was

read there must have been some hot air in the printing office while they were getting it out.

Such examples as these might be cited indefinitely by any of you.

Many other forms of popular advertising are so common as to excite no comment. One such is the quasi-popular article, in semi-popular language on purely medical topics which appear in the daily press with the picture and M. D. of the writer and even with his office address.

Now, to come back to the question. Who are these men? let me ask? Whose photographs are most familiar to us in the public press? Who are the men who are most noted for grand-stand plays? and whose desire for notoriety permits them to use the newspapers and play to the gallery by every means possible?

Are they the young, unknown men of the profession who have no reputation to lose? No. Most of them are men who have already achieved success. Many of them are members of the national and state medical societies, and to come nearer at home, nearly all of them are members of our local societies. Some are men who have acquired more than a national reputation and all are old enough in years and practice to be looked up to as teachers and examples by our younger men.

Do the societies countenance these methods? Surely silence gives consent. The only instances of any attempt at discipline in our local societies in the past ten years to my knowledge have been two. One by the Chicago Medical Society and one by this body.

One offender was a young, unknown man with no reputation, except for unusually good laboratory work, who happened to talk to a reportorial friend about some of his work and got five lines in the daily paper. He was a shining mark! The other offense was more flagrant, but the offender was insignificant compared to many we know.

Now, on the other hand, if the sentiment of the best element is against the methods I have described, and I believe it is, why are the offenders not brought to account at the bar of the societies instead of having fresh honors heaped upon them? Perhaps the answer to the question is to be found in an incident that occurred in this city recently—

The agent for an insurance company which insures physicians and surgeons against malpractice and blackmail suits called upon one of our prominent surgeons. In explaining the scheme he described the sliding scale plan of premiums by which the cost increases with the income of the insured.

The surgeon at once objected to that plan and said "That is wrong. You ought to turn that scale around and charge the unknown man of small income the most and the prominent men of large income the least. The man of no reputation is the greatest risk. They are the ones who are sued. How often do you hear of a great surgeon or physician being sued? They are afraid to tackle us noted men."



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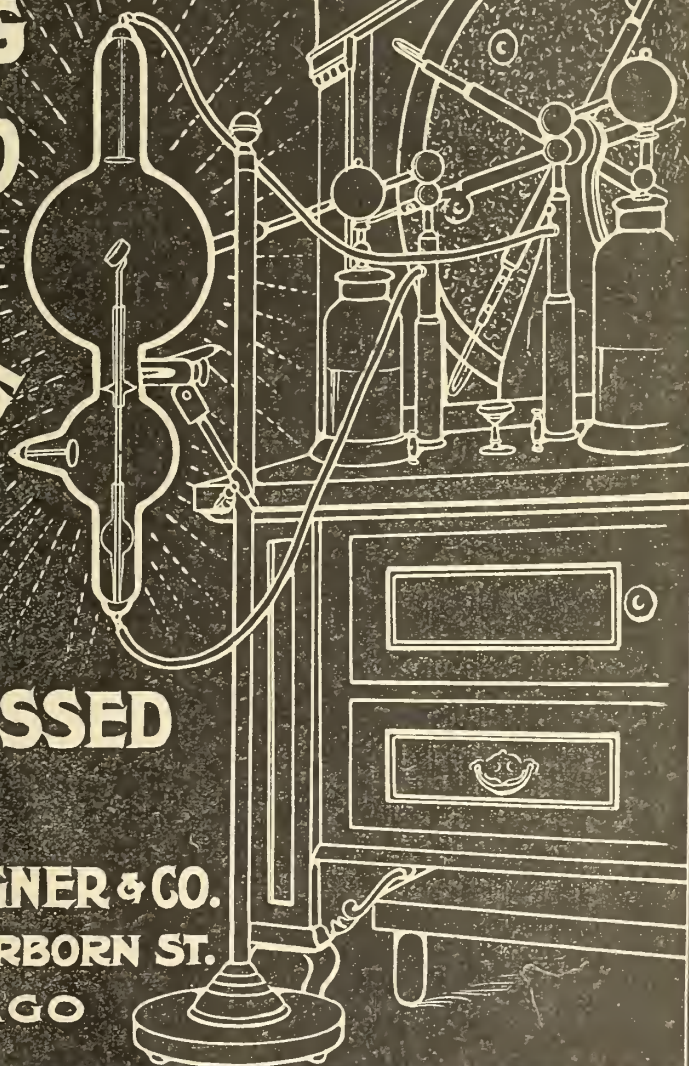
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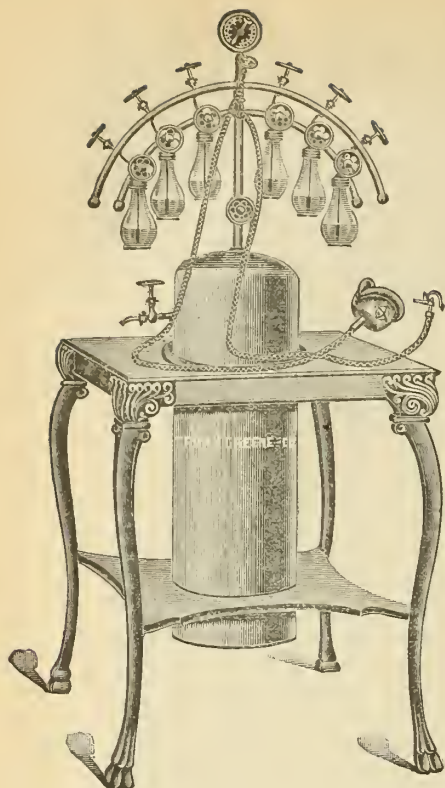
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Volume LII.  
New Series, Vol. IV. }  
Number 3.

Springfield, Ill., August, 1902.

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FOR SPECIAL FEATURES SEE FIRST EDITORIAL ARTICLE.

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Springfield, Ill., August, 1902.

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## THE STOKES-ADAMS SYNDROME, WITH REPORT OF TWO CASES.\*

BY FRANK BILLINGS, M. D., CHICAGO.

The Stokes-Adams Syndrome or disease was first discovered by Adams and later studied more fully by Smith and Stokes. Huchard made an exhaustive study of the condition at a later date and proposed the association of the names of Adams and Stokes with it.

The phenomena which characterize the disease consist of a permanent slow pulse with attacks of giddiness or faintness or transient unconsciousness or of epileptiform convulsive seizures.

Attending these characteristic symptoms is usually a subjective breathlessness or a dyspnoea, and the patient is usually pale, especially just before an attack of unconsciousness.

Beside these phenomena there may attend as symptoms or signs any of the phenomena usually associated with cardiac and blood vessel disease, viz., various degrees of angina pectoris, Cheyne-Stokes phenomenon, cardiac asthma and at some time in the course of the disease may occur more permanent signs of cardiac failure in the way of venous congestion of lungs and the abdominal organs, and dropsy.

The pulse is characterized by the fact that in a classic case it is slow ranging anywhere from five per minute, as in Halberton's case, to fifty. Usually each arterial pulse is distinct and quick and usually regular, although there may be an associated irregularity which is hard to detect if the pulsations per minute be few. In listening over the heart the chief characteristic is the great length between the second and first tones of the heart. In some cases there may be an incomplete contraction of the ventricles, not sufficient to send the blood

wave, as a perceptible pulse to the wrist. Aside from the above characteristic phenomena of the heart action and radial pulse, there is nothing present which may not be found in the various cardiac diseases. It may be said however that these phenomena are not common in valvular disease and when murmurs are present they are more frequently due to relative valvular insufficiency than to disease of the leaflets.

The attacks of syncope vary in intensity from a slight giddiness to complete unconsciousness, with or without convulsions. The syncopal attacks may be repeated many times and the patient usually dies in one. The following cases present the syndrome in a classic way.

Case 1. Male, age 46, white, born in the United States, a teamster by occupation, came to me about the middle of February, 1902.

His family history was unimportant. He denied venereal disease. He drank 4 or 5 glasses of whiskey daily and sometimes used beer. He smoked a pipe excessively.

He had jaundice at 31 which lasted eight weeks, but does not remember being sick at any other time.

As a teamster he was obliged to lift heavy pieces of merchandise and seven months ago, while lifting a heavy weight, he felt a sharp pain in the left chest in the region of the nipple. At the same time he had a feeling of suffocation and coughed but did not expectorate blood. For the next few days exercise produced pain in the region of the heart and shortness of breath and he was obliged to remain quiet. After eight weeks he returned to work at which he continued until seven weeks ago, at which time, when beginning work one morning, he fell to the ground unconscious. He was told that he did not have convulsive movements of the extremities and that his unconsciousness lasted but a minute. He was able to get up and go about his work. Since

\* Read at the 52d Annual Meeting, Quincy, May 20, 1902.



that time he has fallen unconscious five times, but has had no convulsive movements so far as he can learn from his friends. He has not bitten the tongue nor has there been a froth about the mouth when he has recovered consciousness. There has been no involuntary discharge of bladder or bowel during the seizures.

Since the beginning of his illness, seven months ago, he has had shortness of breath upon exertion and, when over-exerting himself, has felt uncomfortable from dyspnoea and has coughed. There has been no difficulty in swallowing and there has been no disturbance of the digestive tract excepting slight constipation. He has lost 25 pounds during the last seven months.

On examination the patient appeared fairly well nourished and of good color. His radial pulse was 40 to the minute and regular when sitting. The respirations were 18 per minute and the temperature was 98° F. It was noticed that the right pupil was dilated and fixed, but this condition the patient explained had occurred in childhood from an injury and it probably, therefore, had nothing to do with his present condition. The heart dullness extended 1 in. to the left of the left nipple, the right border to 1 in. beyond the right border of the sternum and the upper border dullness extended upward and to the right from the third rib to the first interspace on the right side. This area of dullness was easily mapped out and appeared to cover the area of the ascending arch of the aorta and to extend slightly above and to the right of the sternum. The apex beat could not be seen but could be located in the fifth interspace in the nipple line.

A diastolic roughness not a murmur could be heard at the second right interspace.

While under observation at a later date, a systolic murmur could at times be heard in the mitral area and the second aortic sound was some times accentuated.

The lungs showed nothing important. The liver was palpable below the costal arch but was not indurated nor tender. The spleen was not palpable. There was no tracheal tugging. There was no laryngeal paralysis and there was no throbbing or thrill

to be felt over the upper chest in the region of the abnormal area of dullness.

A sphygmogram showed a normal tracing as to individual beats and time of each complete systole. The diastole was very much prolonged. A skiagram showed a shadow in the region of the abnormal dull area.

A 24 hour collection of urine amounted to 950 c. c., the specific gravity 1.021, acid reaction, no albumin, no sugar, no casts, no blood. Total solids for 24 hours were 46 grammes, the urica 2.3 per cent. or about 22 grm. for 24 hours.

The patient was admitted to the Presbyterian Hospital on February 19 and remained there under observation until the 18th of March. While in the hospital his highest pulse observed, at one time, was 60. Usually his pulse was below 40, sometimes reaching as high as 48. The lowest pulse recorded was 32. His morning temperature in the mouth was usually 97 and the evening temperature rarely above 98. The respirations were regular and ranged from 14 to 18. The bowels were usually constipated and required a saline.

Many examinations of this patient were made and the findings as noticed were confirmed. A diagnosis of aneurism of the arch of the aorta was made attended with the Stokes-Adams syndrome. While in the hospital the patient had no syncopal attacks and when seen last, on the 10th of April, he had no attacks of unconsciousness. With rest in bed and the systematic care in the hospital he had subjectively improved and no longer had shortness of breath, nor dizziness, and he felt so well that he finally requested to be allowed to go to work again.

His treatment consisted of rest and a simple mixed diet with 5 to 10 gr. doses of the iodide of sodium three times a day.

Case. II. Man, age 59, white, born in Holland, a laborer, was admitted to the Presbyterian Hospital on the 19th of February, 1902, in the service of Dr. J. B. Herrick, who was kind enough to allow me to report the case.

The father died of tuberculosis at the age of 42. One sister and one brother also

died of the disease. The mother is still living at 84, and one brother is well at the age of 66. The patient says he had measles in childhood, but does not remember any other illness until 14 months ago. He denies venereal disease. He has used beer in moderate quantities and has smoked steadily for years.

He says that 14 months ago while sitting, he suddenly fell over unconscious. He does not remember whether he had a convulsive seizure or not, but when he gained consciousness there was a sharp pain in the right side of the head which continued for about 6 weeks. He was unable to go about, although he says that he could use all of his muscles well. Following this he had many attacks of dizziness which came on suddenly, in which he would lose consciousness but would not fall. About one year ago he had an attack of severe pain in the region of the heart attended with a sense of constriction and shortness of breath. There was some cough and he says that he expectorated some blood. His bowels have been constipated but there has been no other disturbance of the digestive tract.

On examination he appears to be about 60 years of age, is well developed and fairly well nourished. The chest is large and somewhat barrel-shaped. The lungs are hyperresonant. The respiratory murmur is clear but of the emphysematous type. The upper border of heart dullness is at the third rib. It extends to the nipple line on the left and to the right sternal border on the right. The heart tones are clear but very faint and the heart action is unsteady. The systole is not always complete and some blood waves do not reach the radial artery as a perceptible pulse. Counting the heart beats with the stethoscope it varies from 40 to 56 per minute, while the radial pulse ranges from 30 to 50. There are no cardiac murmurs. The abdominal organs are negative.

The urine is scant, the 24 hour collection 350 c. c., specific gravity 1.020, urea 1.7 per cent. or 6 grammes in 24 hours and the total solids 16.5 grammes. A later collection gave 1100 c. c. in 24 hours with

an improvement in the total urea and total solids excreted. The palpable arteries were everywhere thickened and tortuous and there was an arcus senilis.

He remained in the hospital until the 1st of April and while under observation presented practically the findings above named. His pulse was often irregular and sometimes perfectly regular and usually slow, ranging from 40 to 50 beats per minute. The temperature was often 97 in the morning and rarely above 98 in the evening; the respirations ranging from 16 to 20. He had many giddy attacks while in the hospital in which, while sitting, he would momentarily lose consciousness. He improved steadily, however, and, during the latter part of his stay in the hospital, had no attacks and the pulse improved as to its regularity although it remained slow.

Repeated examinations and observations of over a month seemed to justify the diagnosis of fibrous myocarditis with associated senile arteriosclerosis and the Stokes-Adams syndrome.

I have quoted these two cases rather fully for the purpose of demonstrating two entirely different pathological conditions as to the cardio-vascular system, with practically the same symptom complex, although the first case presented the phenomena of Stokes-Adams more typically than the second.

Dr. D. W. Prentice of Washington (Transactions of the Association of American Physicians, 1889 and 1890), quoted and reported 96 cases in which he, after analysis, concluded that the slow pulse may be produced by disease from injury of the pneumogastric or sympathetic nerves or their centers or of the cardiac ganglia or of the heart muscle.

Balfour, quoted by Gibson (Diseases of the Heart and Aorta, 1898), thinks a slow pulse is not due necessarily to any cardiac lesion but to cervical inhibition acting through the accessory nerve. Huchard, quoted by the same author, thinks the majority of cases are due to sclerosis of the coronary arteries and to bulbar ischemia.

In cases reported by Robert T. Edes of Boston (American Medicine, May 18th,

1901, p. 299), a case is reported with autopsy which showed the coronary arteries normal, the myocardium normal, atheromatous plaques at the beginning of the thoracic aorta and with normal arteries at the base of the brain. In 1891 Dr. Edes reported upon a case of Dr. Prentice of Washington. (Transactions Association of Physicians, 1891, p. 259), of a man of 53 with a pulse ranging from 11 to 40 per minute, who, for two years, had had frequent attacks of syncope. Clinically no disease of the heart or other organs could be discovered. During the last two months he had frequent dizzy and syncopal attacks and for several days before his death was delirious. He died suddenly. The heart muscle appeared normal. The aorta and the coronary arteries were not atheromatous. Brain, cord and medulla appeared normal. The terminal twigs of the pneumogastric showed fusiform enlargements at the point of separation of the cardiac branches from the recurrent laryngeal and appeared to show a connective tissue. Other nerves, including the cardiac plexuses and the ganglionic cells, were normal. No intrinsic cardiac ganglia were found. The few changes found in this case were not considered necessarily pathological.

We have, therefore, no pathological anatomy in these cases which is constant and the syndrome must be considered simply as clinical phenomena occurring in different pathological conditions.

It is agreed that the dizziness and syncopal attacks were probably due to the lessened blood supply to the brain. This is evinced by either continued pallor of the face or by pallor preceding the attacks. That there may be an associated vaso-motor spasm as occurs in epilepsy is admitted. The slowness of the pulse is a phenomenon which may occur in many different conditions. As Regal has shown, it may be physiological as it appears in the puerperal state, falling to from 34 to 36 per minute. Its explanation here is not clear. The radial pulse may be slow as a family trait. Napoleon is said to have had a pulse of only 40 to the minute, and many other cases equally slow have been recorded in which

there was no evidence of disease. Pathological bradycardia may occur in exhausted states like that which follows the acute infections, notably typhoid fever, diphtheria, pneumonia, rheumatism, gastro-intestinal disease and also in exhaustion from overwork. It may occur in diseases of the heart and blood vessels and usually in diseases of the heart in which fatty or fibroid cardiac changes have occurred. It may occur as the result of toxemia due to tobacco, lead, alcohol, tea and coffee, digitalis and in toxic conditions incident to uraemia and gastro-intestinal disorders. In diseases of the nervous system like apoplexy, cerebral tumors, epilepsy, diseases of the spinal cord and medulla, in hysteria, insanity and paresis, and finally it may appear as the result of pain, over-heating like insolation, etc.

In summing up the present knowledge of the pathology and the cause of slow pulse, Dr. Edes (*Loc. cit.*) comes to the following conclusions:

A permanent slow pulse depends upon weakness or paresis of the augmentor or accelerator system. This may take place in any portion of its course; in some very marked cases it is the result of injury to the cervical spinal cord. In the majority of medical cases it is supposed to be connected with degeneration of the cardiac ganglia but evidence of this is, as yet, more physiological and clinical than anatomical. It is decidedly a symptom indicating weakening of the heart. The paroxysms are the consequence of reflex excitation of the vagus, which may be no more than normal, acting against an antagonist while weakened by degenerative changes (and, perhaps, also by frequent defects from the same conqueror).

The diagnosis of the case when typical is easy as the characteristic slow pulse with the syncopal attacks are pathognomonic. It must be remembered, however, that a radial pulse is not always the index of the heart pulsation. A weakened systole may not send a wave sufficiently forceful to be felt at the wrist and the radial pulse of 36 may represent a heart action of 72. Furthermore epilepsy may be associated with slow



pulse and it would take close observation over a considerable period of time to enable one to say it was not the Stokes-Adams syndrome. The diagnosis would be easily confirmed by observation over a considerable period as the pulse is permanently slow and the disease progressive so that the patient is apt to have an increasing number of syncope attacks.

The prognosis is uncertain, and depends, of course, entirely upon the basic cardio-vascular disease. There are records of cases extending over many years. Osler reports the history of one patient who was known to have a slow pulse for 30 years. As the disease commonly occurs however in relatively old people (Adams' case first reported was 68 and Stokes' two cases were 56 and 68, respectively), and as the disease is usually associated with grave degenerative cardiac disease and therefore progressive, the end may come suddenly in a syncope attack at any time.

The treatment should be based upon the cardio-vascular condition. The nitrites and iodides frequently give relief to the syncope attacks. Digitalis has been known to quicken instead of slow the heart. French writers have advocated the use of a milk diet and have reported marked improvement in the cases so treated.

During the paroxysm the nitrites with diffusible stimulants are the most beneficial.

#### Discussion.

**James B. Herrick**, of Chicago: My attention was first called to the Stokes-Adams syndrome in 1900. Whether any cases had been seen by me previous to that time, I do not know. If I saw them, I did not recognize them as such. Since then I have seen four cases of Stokes-Adams syndrome, two of them in my service in the Presbyterian Hospital, whose histories were given to you by the essayist. There is little I can add to this very excellent presentation of the subject by Dr. Billings, except perhaps to refer to two other cases that have come under my observation. One of them I saw but once during a consultation with another physician. She was an old lady, who had decidedly sclerotic vessels, an hypertrophied heart, and corresponding in its physical signs to the arterio-sclerotic heart. This old lady had fallen into a fit of unconsciousness three or four times. That was the first case. The other case was one that I had the opportunity of watching until her death. It was a woman forty-seven years old, who was

an unusually bright and intellectual woman. She had written a great deal for the papers, had lectured on the lecture platform, and was given to phrenology, so that when I was first called in to see her and heard her story, I thought that there was a tendency to exaggeration, and a peculiar interpretation of symptoms. I was inclined to look on her history of these peculiar attacks during which she was said to become unconscious as the exaggeration of a neurasthenic, and particularly as she had told me that she had suffered from nervous prostration three or four years before. She knew that she had had a remarkably slow pulse for a few years previously. The first attack of which I could get any definite history or data occurred while she was reading. As she was reading she felt a peculiar pain in the back of the head and asked her nurse to rub the head. Before the nurse, however, could reach her, she had fallen from the chair unconscious. Within two days she had six attacks like that, and before I came to see her she had not only had these six attacks, but seven or eight others.

When I examined her I could find nothing abnormal until I made the physical examination of the chest. I found the heart slightly enlarged, with a frequent systolic rubbing at the apex, heart tones feeble, the sounds of the heart and the pulse at the wrist indicating a heart beat of from twenty-four to thirty-six. As I have stated, I was inclined to disbelieve her statements with regard to the attacks, until one day, as I was counting her pulse, she suddenly said to me, "Doctor, it is coming on." With that her eyes rolled up and she had a genuine epileptic convulsion, not an attack of syncope, but genuine epileptic seizure. I then saw that there was something apart from neurasthenia or hysteria. I asked Dr. Patrick to come and see the case with me, and we both agreed that we had to deal with a sclerotic heart and sclerotic vessels of the brain, but neither of us recognized at the time that it was a case of Stokes-Adams syndrome. A few days later Dr. Patrick called me up and said that he had found a description of Stokes-Adams syndrome which corresponded exactly with our case. Several days after that I, too, found a description; the best ever written, in my Bouchard. She complained of weakness, disagreeable sensations in the epigastrium, and heart, and she would have frequent slight attacks resembling a petit mal. Later, she got much worse, her mind became feeble, she had Cheyne-Stokes respiration, and ultimately became very weak and feeble, and died. No autopsy was permitted in this case, so that I was unable to confirm my clinical diagnosis by the anatomical findings.

All the cases I have ever seen have been associated with distinct vascular changes resembling the type of disease called by Bouchard cardio-bulbar diseases. There are cases on record which were absolutely negative so far as the vascular changes are concerned. Within a few days the *Deutsches Archiv für Klinische Medizin* contained a very fine ar-

ticle on this disease by Jacquet. He performed an autopsy on his case, but found absolutely nothing, and he, too, raised the question which was propounded by Dr. Billings, whether some of these cases might not be vaso-motor in origin, without presenting any genuine organic changes in the vessel.

**Robert H. Babcock**, of Chicago: The very interesting cases which have been narrated by both Drs. Billings and Herrick correspond with the type of diseases as portrayed by older writers, such as Stokes and Adams. They have all been cases occurring at an advanced age, and showing cardio-vascular changes. There appears to be a type of cases, however, occurring in much younger individuals, in whom, as already stated, there are no changes discoverable at the autopsy, nor clinically. The case reported by Jacquet and referred to by Dr. Herrick was a very young individual, and it is important to remember that. Hoffmann narrated the case of a young woman who presented typical attacks, and in whom he could not demonstrate clinically any cardiac lesion. She was very anemic, however, and appears to have recovered under proper treatment for the anemia and the inhalation of oxygen.

During the past two years I have had under observation the third patient who has presented the typical phenomena known as the Stokes-Adams syndrome. This is a young man, twenty-six years of age, who has an aortic stenosis. For the past two and a half years he has had attacks corresponding with the syndrome in question, but only within the last few months there came on distinct attacks of syncope and epileptiform seizures. His case is particularly interesting, because the attacks seem to be precipitated, or called up by some auto-intoxic condition. Something about a year ago last Christmas holidays I saw him after he had been suffering for months without any relief whatever, and having failed to hit upon anything which gave him any relief, I, in sheer desperation, suggested an absolutely strict vegetarian diet. His urine showed indican in excess. On that strictly non-animal, vegetarian diet he went five months without any attack. Then, becoming somewhat reassured, and feeling comparatively safe, he gradually returned to his former mixed diet, with the result, as I expected, that something like three or four months ago the attacks returned with redoubled fury. At times he would have attacks every few minutes, typical, as described by the former speakers, and he has had repeated attacks since that time. The interesting feature is this, that during the period when his attacks are on, either with more or less frequency and severity, his urine shows a retention of solids, and particularly a retention of indican and also of oxalic acid. When, however, he is absolutely free from his attacks, and the amount of solids is increased, then the indican comes up to three and four times the normal amount. This young man appears to be comparatively free from these attacks so long as I can make

him eliminate properly and keep his intestinal digestion nearly normal.

Another interesting feature in his case is that at times recently his pulse will suddenly mount up to 72 and even 80, but only for a short time. This increase in the pulse appears to usher in one of his attacks. When he is at his best, as during the five months he was living on strict vegetable diet, his pulse averaged 29 beats, although there were always two very feeble cardiac contractions between every two vigorous contractions, so that, as a matter of fact, his heart was striking 72 beats per minute. No matter how slow the pulse is, so long as it is regular, he has no attack, but if irregular, his cardiac contractions are so feeble as to fail to support the intracranial blood pressure, and then his attacks come on.

**Sanger Brown**, of Chicago: I was not able to hear all of the paper, but from a neurological standpoint this subject is intensely interesting. I do not remember whether Dr. Billings mentioned what I am about to say, but among the various causes which might produce this symptom-complex, brain tumor would, I think, furnish more cases than any other one cause. I think that fact would very much support Dr. Billings' explanation in regard to the pathology of these cases that do not present any changes.

**L. H. Mettler**, of Chicago: I would like to have Dr. Billings tell us in his closing remarks whether there is any difference in this pulse when slow in any other respect between those cases that are probably without organic lesion or possibly neurotic or toxic in origin from those that have cardio-vascular disturbances. He has given a number of possible pathologic causes, and it seems to me from what I can gather that in the neurological cases the pulse is always more regular and even, even if slow. Whether there is any difference in these latter cases, where the pulse might be more fluctuating and trembling. I simply ask for an opinion.

**Dr. Boone**: I would like to ask Dr. Herrick whether, in the case which he had under observation until death, the pulse stopped immediately when these attacks came on, or whether there was a certain stoppage of the pulse at the time of the attack? I would also like to know in connection with the etiology of the disease whether he has noticed that it is associated with any of the acute infectious diseases, such as typhoid fever. It has occurred to me that this might possibly be an etiologic factor.

**James B. Herrick**, of Chicago: The pulse of the patient I described, as a rule, ran about 35 to the minute, just before an attack. The patient always said she could feel the heart stop, then give a thump, and this would usually initiate the attack. During the attack the pulse became very weak and more rapid, but in the intervals between the attacks it was always a slow pulse. I never found it over 44.

**Dr. Billings** (closing the discussion): I did mention brain lesions and especially brain tumors as a cause of slow pulse, but not as a cause of this disease. There is no case on record, at least, I have not been able to find it, in which the Stokes-Adams syndrome is present in cases of brain tumor.

In answer to Dr. Mettler's question, in the cases recited by me there was one which had been admitted to the Presbyterian Hospital under the care of Dr. Herrick. The diagnosis of fibrous myocarditis was made, because of the physical findings, and because of the irregularity of the heart and the radial pulse. Some ventricular contractions of the heart were felt that were not strong enough to be felt at the radial pulse. There are many of these cases in which there are clinical evidences of cardiac or vascular disease. As to the cases in which there is no perceptible clinical evidence of cardiac disease, I do not know about that. I suppose it would indicate simply the conditions present.

In the first case reported, in which the clinical diagnosis of aneurysm of the arch of the aorta was made, the pulse was always regular and full, and, so far as I was able to ascertain, the contraction of the ventricle was strong enough to be felt at the radial pulse, and consequently the heart beats and the pulse beats always correspond in number.

As far as spinal cord lesions are concerned, I am not sufficiently familiar with these cases to say whether they would give a pulse similar to or different from what I have mentioned in my paper.

## REPORT OF A CASE OF CONGENITAL DISLOCATION OF BOTH HIPS.\*

Successfully Treated by the "Lorenz Functional Weight Method."

BY EDWARD H. OCHSNER, B. S., M. D.

Attending Surgeon Augustana and St. Mary's Hospitals,  
Adjunct Professor of Clinical Surgery, Medical  
Department, University of Illinois.

In the early part of 1896 it was my good fortune to be present at a meeting of the Vienna Medical Society, when Professor A. Lorenz exhibited his first series of cases successfully treated by his "Bloodless Functional Weight Method." Later in the year I was granted the privilege of witnessing one of the first and most enthusiastic followers of Lorenz, Dr. Kummel of Hamburg, successfully treat a number of cases of congenital dislocation of the hip. I was permitted to see the cases from time to

time for the subsequent six months and became further impressed with the value and efficacy of the method.

When in the fall of 1898 my brother requested me to take charge of a little patient suffering from double congenital dislocation of the hips, who had been referred to us by Drs. Hodgson and Jacobs of Waukesha, Wisconsin, I consented to try reduction by a method which I had seen do such excellent service in other hands. It is my purpose to report this case in detail with a few comments and conclusions, not going into the subject of congenital dislocation in general as such would be impossible in the short time allotted to me.

On October 24, 1898, the little lady four years and three months of age presented herself for examination, and for treatment, if in our opinion it seemed possible to give her parents any encouragement in the matter. At that time I elicited the ensuing history and noted the following conditions: Family history very good. No history of similar trouble, or any deformity among the members of the family, or of any of the ancestors or relatives. Born at term, labor very easy, but mother noticed that there was much less liquor amnii than with former pregnancies. Weighed six pounds at time of birth, apparently perfectly healthy. No history of injury to mother during the pregnancy or to child after birth. Mother had been very weak during the pregnancy, as this was the third child in three years, and she nursed the previous one until five months before this one was born. Mother had not noticed anything unusual during this pregnancy except that she thought she had not "felt as much life," as during the two previous ones. During the first three months the baby had two very severe attacks of cholera infantum. Mother noticed nothing peculiar about the child except the hips seemed rather prominent. The child did not attempt to walk until she was two years old, and when she did she began by walking on all fours, and continued this for a long time especially when in a hurry. Later when attempting to walk erect she was very unsteady and fell very easily. She was two and one-half

\* Read at the 53d Annual Meeting, Quincy, May 20, 1902.

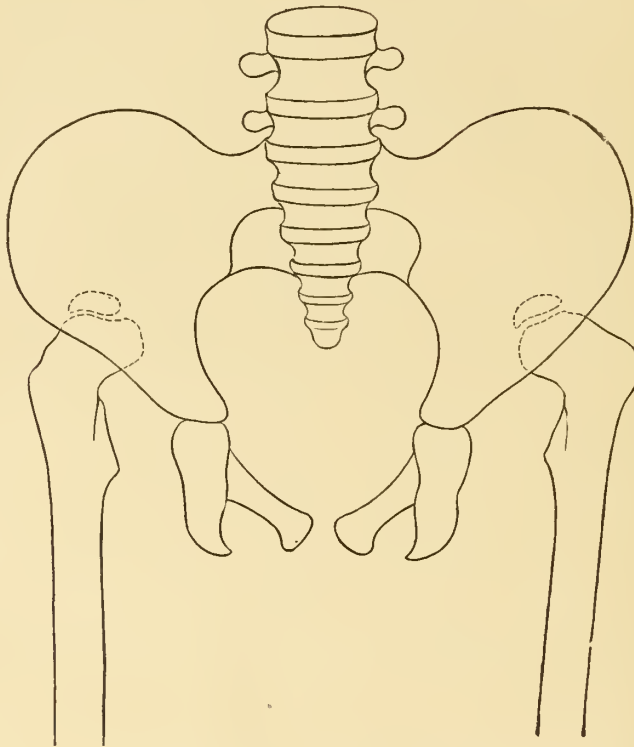


years old before she could walk the length of the room without falling and always became fatigued very easily.

On examination I found a well nourished child rather small for her age, only 87 c. m. tall with the distance from the anterior superior spines of the ilia to internal malleolus of each side 39 c. m. Heart, lungs and abdomen negative. Digestive and excretory

of course immediately made a diagnosis of double congenital dislocation of the hips, as a more typical case could scarcely be found. In order to make doubly sure and in order to get an idea of the condition of the upper ends of the femura and the acetabula, and hence as to probable prognosis, for at that time it was still thought that the X-ray could give valuable information on this

*Fig 1*



functions normal. On directing her to walk, the prominence of the hips, the marked lordosis, the protrusion of the abdomen and waddling gait immediately attracted my attention. On closer examination, the upper borders of the great trochanters were found 5 c. m. above Nelaton's lines, the heads could be felt on the posterior surfaces of ilia instead of in the groin, there was hyper-mobility of the heads of the femura and of the thighs.

On these findings and this history we

point, we had the skiagraph taken, of which Fig. 1 is an accurate pen sketch. On closer observation we note that the heads are about half way between the anterior superior and the anterior inferior spines of the ilia instead of being opposite the Y cartilages, which are shown by lighter lines in the skiagraph. Heads and necks appear well formed and the acetabula fairly well developed.

The degree of displacement becomes more evident when we compare Fig. 1 with Fig. 5, a pen sketch of a skiagraph taken after

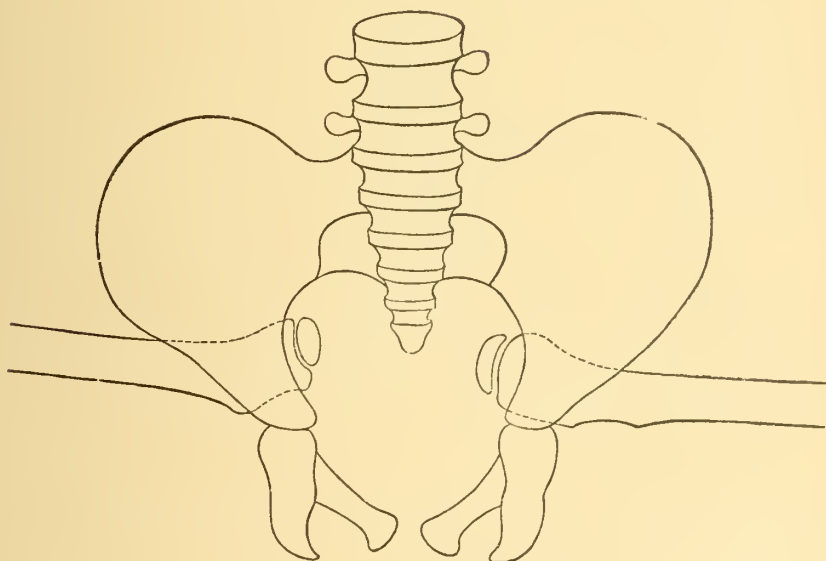
complete recovery.

We now proceeded to treatment and we tried to follow the directions of Lorenz as closely as possible. At that time he still advised Buck's extension for a short period. We accordingly applied this for five days, when we anesthetized the little patient, placed a skein of wool over the perineum and tied the ends to the upper end of the table. Another skein of wool was fastened around the left ankle. The latter was now attached to a tackle and windlass arrange-

great trochanter with the right and the thigh was slowly abducted and overextended. At this point the head was felt to slide over the posterior ridge of the acetabulum, and with a dull thud, and a plainly felt shock or vibration the head slipped into the acetabulum and the reduction was accomplished.

This was accompanied with a noticeable lengthening of the left thigh, the appearance of a fullness in the left groin and the disappearance of the head on the posterior

*Fig 2*



ment which was then slowly put in motion and under careful watching of the pulse and respiration and with repeated intermissions in the course of about twenty-five minutes the left lower extremity was brought down until the upper border of the great trochanter was slightly below Nelaton's line. The force applied never exceeded fifty pounds as tested by spring scales.

The extension was now relieved, the thigh carefully abducted to a right angle by slow, steady, moulding manipulations. The thigh was now flexed to a right angle, and while traction was made in this direction with the left hand, pressure was made on the

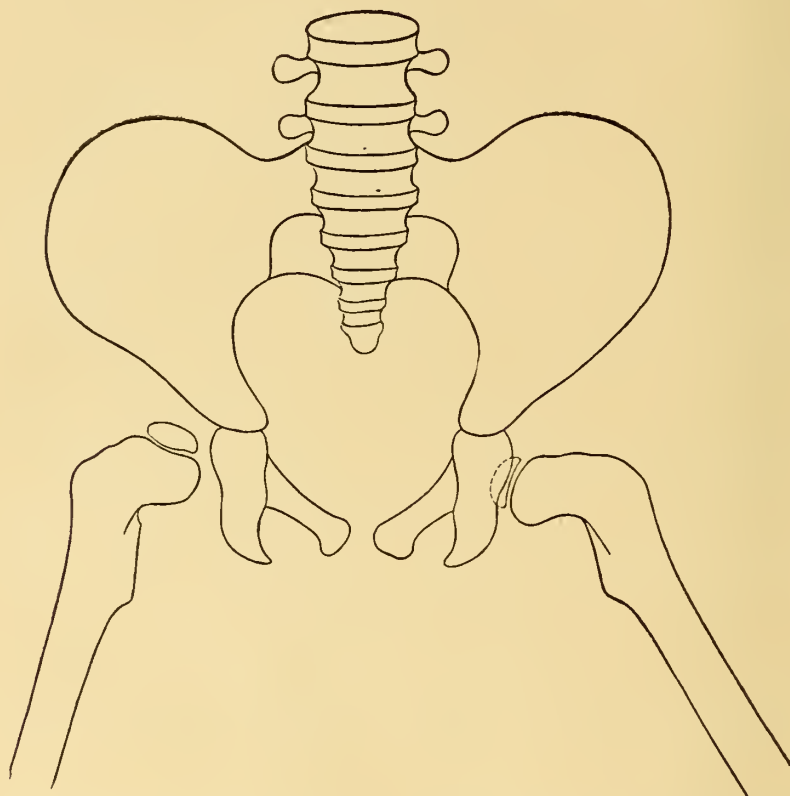
surface of the ilium. On attempting to reduce the angle of abduction relaxation immediately took place. Reduction was easily accomplished with the same characteristic signs. With a boring motion an attempt was now made to enlarge the acetabulum and to stretch the anterior portion of the capsular ligament by pressing the head forcibly against it, hoping in this way to secure greater stability. The left thigh and the trunk to the level of the ribs were now incased in a thin layer of cotton and a plaster of Paris cast applied with the left thigh abducted to 90 per cent in slight overextension. No attempt was made to further

test the stability or to reduce the angle of abduction. One week later the cast was removed and the right reduction accomplished in the same manner, and with the same unmistakable signs. Both thighs and trunk up to the ribs were then incased in cotton and a cast applied.

I now had a skiagraph taken through the

ness in the groins was immediately noticed. The heads could again be felt on the posterior surfaces of the ilia. The skiagraph confirmed my fear that a backward redislocation had taken place. Fig. 2 represents the condition found at the time and shows the position in which the cast had been applied. The following day the patient was

*Fig 3*



cast which, though somewhat blurred, showed the heads in excellent position and evidently reduced. This negative with several others was unfortunately broken, hence I am unable to give a sketch of it.

The patient was allowed to return to her home on the 10th of November, with directions to return in about a month. With this request she complied by returning on December 12th. The cast was now removed and depressions instead of the full-

again anesthetized, both dislocations were reduced with but little difficulty, and with the same characteristic phenomena. The cast was again applied with the legs in the same position, but with greater care. The child was allowed to go home on December 17th, 1898, and returned to the hospital on January 16, 1899. At this time I again found that relaxation had taken place. Once more the patient was anesthetized and reduction accomplished as on the previous

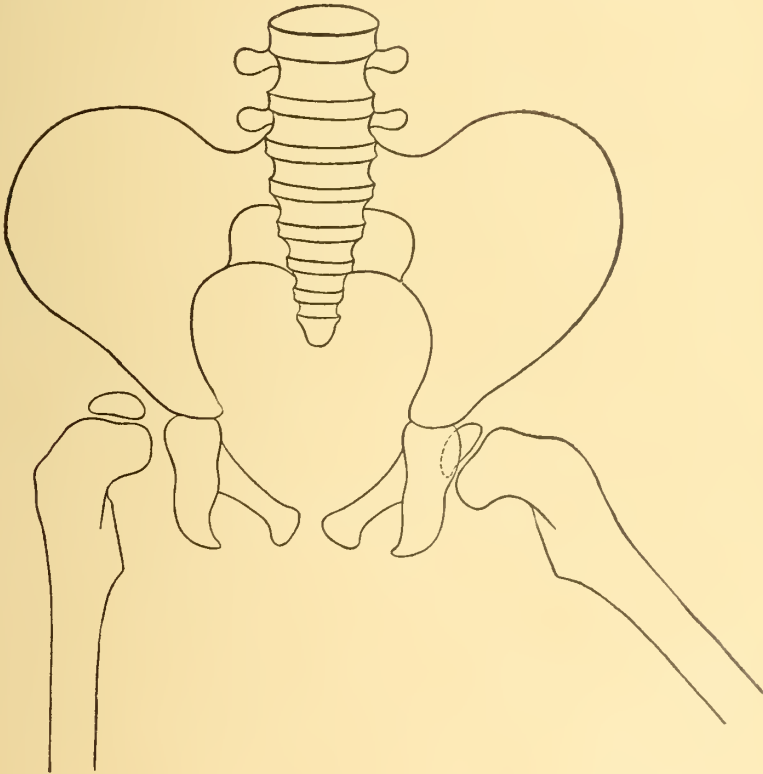


occasions. I had seen Kucimmel use felt under his plaster of Paris and when I began the treatment of this case I tried to procure this material, but for some reason was unable to do so. I now concluded that the cotton which could not be absolutely uniformly applied and which would yield to a sudden jar must be the cause of the re-

ever, that the heads were in place and future developments have proven the correctness of this belief.

The difficulty about the ordinary skiagraph is that it does not give us perspective and in congenital dislocation of the hips, especially when the limbs are held at 90° abduction, lateral views are manifestly im-

*Fig 4*



luxation. In the absence of felt I procured some medium weight, snugly fitting, all wool drawers, and applied the cast over these with both thighs abducted to 90° and slightly overextended. The patient went home on January 25th and returned on February 27th, and to my great satisfaction the physical findings indicated that the heads were in place, though the skiagraph was not perfectly satisfactory, as it left us in some doubt. We concluded, how-

possible. If we had at that time had stereopticon views I am confident it would have cleared up all doubt.

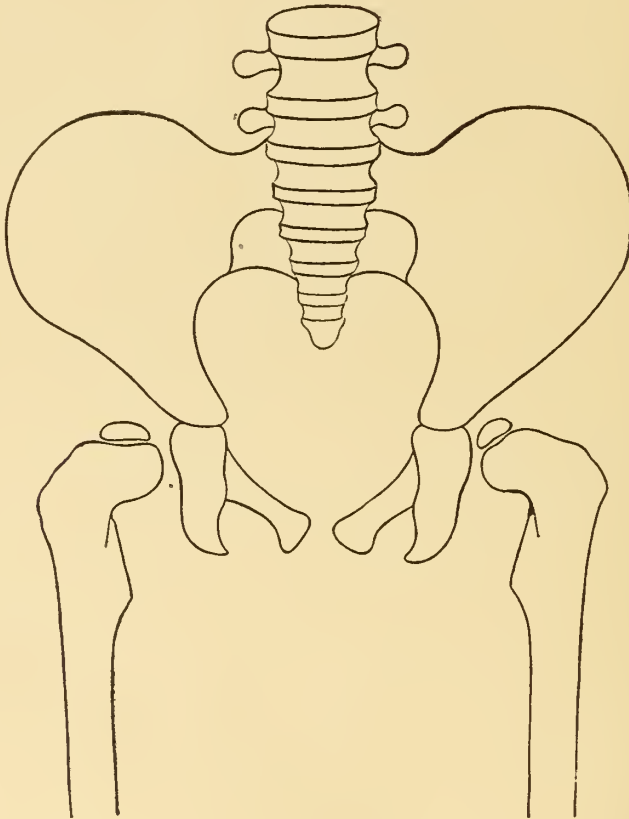
This negative was also broken, and I regret greatly that I cannot give a sketch showing the heads in place at this time.

The little lady was now allowed to sit up on her little stool and to play around at her pleasure. With two changes of cast, the limbs were left in approximately this same position until August 2d, 1899, when

the patient was again anesthetized, and an attempt was made to bring the thighs down into the midposition of Lorenz, namely abduction of about  $45^{\circ}$  with very slight flexion. This was accomplished quite readily on the left side, but the right side offered great, and at first apparently insurmountable resistance, the head seeming to

With four more changes of casts, we obtained the position represented in Fig. 4 by August 27th, 1900. By this time the left thigh was in normal position and motion all but perfect, so that it could be left out of the cast. The right one gave a great deal more trouble. There was still marked rigidity and abduction and a decided ten-

*Fig 5*



catch on the lower border or lip of the acetabulum, and I succeeded in bringing the limb down only a very little. A cast was applied in this position and allowed to remain until January 1st, 1900, when the patient was again anesthetized, and the position represented in Fig. 3 was secured. In this you see we have accomplished a great deal with the left thigh, and the right thigh is almost in the midposition of Lorenz.

deny to contracture (flexion) at the hip, hence I was compelled again to anesthetize the patient and to forcibly overcome the contracture and to apply a cast with the right thigh in the position of normal extension and about  $10^{\circ}$  of abduction which I could not overcome without applying an undue amount of force. This cast was left in place until November 10th, when it had become soft, and had to be replaced

by a stronger one. At this time the last skiagraph, which is represented by Fig. 5, was taken. This shows the heads in their normal position opposite the Y cartilages, well below the anterior inferior spines of the ilia. January 1st the cast was removed for a day, when there seemed to be a tendency to con-

*Fig 6*



tracture of the right hip and the same cast was re-applied and removed only for half an hour daily. This was gradually lengthened and February 15th, 1901, the cast was permanently discarded.

By this time the muscles of the left thigh had developed nicely and now with exercise and gentle massage the muscles of the right leg also developed rapidly, so that October 2d, 1901, I received the following letter from the mother, the patient having moved to Colorado in the meantime. The mother

states: "The child is the picture of health and walks beautifully. The stiffness is almost entirely gone from the right hip, and you would be surprised to see how nearly perfect her walk is. She is the greatest mountain climber in the family, as she never gets short of breath and never complains of her limbs being tired."

Subsequently I was told that she had learned to skip rope of her own accord, and to sit tailor fashion without difficulty. At about this time I had a profile photograph taken, of which Fig. 6 is a pen sketch. Though the patient is leaning forward a little, there is not a trace of the former lordosis, the curve of the back is perfectly normal, there is no prominence of the hips, nor any abdominal protrusion whatsoever.

I had hoped that at this time I could be able to describe the little lady's condition from personal observation, in order to prove that a perfect functional result can at times be obtained, without operative interference, but this was not to be, for on November 27th, 1901, she was suddenly taken ill with some acute intestinal disturbance and on November 29th she died in convulsions. I have, however, that which from a scientific standpoint is more important and more convincing than the walking patient or the skiagraph, namely, the pelvis, which I removed at post-mortem December 1st, 1901.

Before giving a detailed description of the joints, I wish to give the notes Dr. Espy of Trinidad, Colorado, kindly took down for me at the time I made the autopsy.

Total length of body, 109 c. m.

Right anterior superior spine to right internal malleolus, 52½ c. m. Left same.

Greatest circumference right thigh, 27½ c. m.

Greatest circumference left thigh, 28½ c. m.

Greatest circumference right calf, 19 c. m.

Greatest circumference left calf, 19 c. m.

Right hip easily flexed to 85°, extended to 180°, abducted to 40° and adducted so as to place leg readily on left knee.

Left leg easily flexed to 70°, extended to 180°, abducted to 45°, and adducted same as right.

Some rigor mortis. Abdomen not dis-

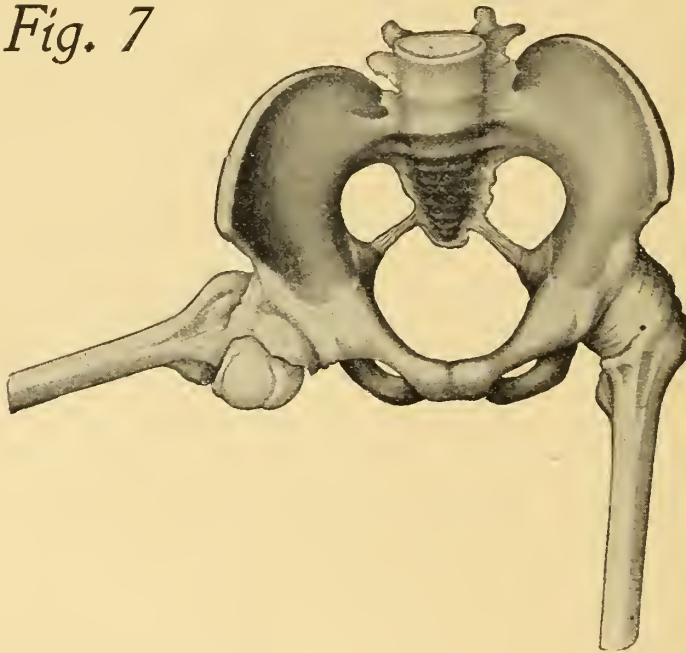


tended. Intestines, spleen, kidney normal. Considerable glairy mucus in the stomach.

Having promised to do nothing which might later interfere with the easy management of the corpse, I had to limit my investigation to a superficial examination of the thoracic viscera through an incision in the diaphragm and to an examination of the hip joints. In order to do the latter more thoroughly at my leisure and to have the specimen as proof positive of the possibility of a reduction I persuaded the parents to permit me to remove the pelvis and

lages. A straight line drawn through the two Y cartilages passes apparently directly through the center of the heads and about  $\frac{1}{2}$  c. m. below the upper borders of the great trochanters. The upper borders of the heads are well below the anterior inferior spines of the ilia. The lower borders of the heads project fully  $\frac{1}{2}$  c. m. below the level of the iliopectineal eminences. So far this description tallies almost perfectly with that of a normal pelvis which I obtained from a female about eight years of age. In the latter the Y cartilages seem

*Fig. 7*



the femura. In removing these I examined the muscles and tendons about the hip joints and so far as I could tell they were perfectly normal. There was no evidence of healed lacerations. On examining the specimen carefully, of which Fig. 7 is an accurate reproduction, we note the following facts: The pelvis is well formed and apparently of normal size. The individual bones of which it is composed are held together firmly by strong ligaments. The capsular ligaments are well developed and hold the heads firmly in the acetabula. No abnormal sliding motion possible. The heads of the femura are opposite the Y carti-

to be relatively a little nearer to the anterior inferior spines.

In order to determine the condition of the reduced joint itself I opened the right one by a semi-lunar incision, severing the capsular ligament for about the lower half of its extent. The neck is strong, of about normal length, the angle between it and the shaft may be a trifle less than that of the ordinary femur. The head is a little larger than normal, not perfectly globular, but on its anterior inferior mesial surface it has the appearance as though a shell of a small sphere had been superimposed. The whole articular surface is covered by a perfectly

smooth layer of cartilage. The capsular ligament is strong and hugs the head and neck closely. The acetabulum is well developed; almost if not quite as deep as normal. It has a well formed solid rim. The cotyloid ligament is present and apparently normal. The articular surface is perfectly smooth. There is no definite ligamentum teres to be found.

At the bottom of the acetabulum I found a thin paper-like structure about 4 m. m. wide and 1.5 m. long, one end attached at the place where the ligamentum teres is normally inserted in the acetabulum and the other end free. Whether this may be looked upon as the remnant of the ligamentum teres, I am unable to say.

The most interesting and wonderful feature of the specimen, to my mind, is the way in which the capsule had adjusted itself to the new conditions. When we again turn to Fig. 1, it must be plain that at the beginning of the treatment the capsule must have been drawn out in the form of a long tube which now has retracted to the normal shape. This is simply an additional proof of the wonderful power nature has to adjust matters and the inherent tendency of the individual members of the human body to attain to a certain normal status.

In conclusion let me observe that from the very beginning of treatment I considered this a rather favorable case. A strong healthy child, with apparently well developed femura, and fairly well developed acetabula, who was at the proper age for such treatment. Those who are most competent to offer an opinion in this matter agree, that the third and fourth years of life are the most favorable.

The errors which I made were: first, in using the cotton under the plaster. I am convinced that this was the cause of the two relaxations, as the cotton between the cast and the body permitted of too much motion and did not hold the parts permanently in the proper relative positions. This error was, however, practically overcome by the exceptional good sense of both mother and child, who were anxious and willing to try again each time as long as

I thought it desirable and was able to give them encouragement.

My second error was in changing the cast too frequently and in employing anesthesia too often, but this I think was excusable and not to be wondered at, when you consider the fact that the first two times on removing the cast I found a relaxation each time. After all, this was not nearly as great a mistake as if I had left the cast on six months the first time while the hip was not in place.

I did not make as full use of the body weight as I should have done, but at that time I did not fully comprehend how far this could be carried. I may have been a little too careful in bringing the thighs down to the normal position, but I am sure even now that this is much the better side on which to err. To wear a cast a few months longer than is absolutely necessary is no special hardship to a child, especially when the child can be about. In fact the last few months of treatment this little patient went to school wearing the cast and experienced no discomfort from it.

I have given this history thus in detail, knowing that these patients have been the bugbear of physicians and surgeons for centuries because of their inability to successfully treat them. Until recently these poor patients and their deeply concerned parents have been put off with a shrug of the shoulder by even the most learned members of our profession, and they have consequently become easy prey to the charlatans and quacks, who promise to cure all cases for a consideration paid in advance. It thus manifestly becomes our duty to report such cases with the greatest possible detail.

Here I believe we have a specimen which will convince even the most skeptical that we have obtained an almost perfect anatomical result, a joint which would always have been stable, which would have supported the weight of the body under all ordinary circumstances, and one which would permanently have insured a perfect functional result.

#### Discussion.

William E. Schroeder, of Chicago: Mr. President, I would like to say a few words about Dr. Ochsner's case. First, I wish to compliment him on the excellent result, which was

due largely to the fact that the head of the femur had been absorbed only in part and the acetabulum was in good condition. In a case I had, after twelve or fourteen reductions, there was only slight benefit. It was the case of a child, and the head of the femur was atrophied, as shown by the skiagraph. In those cases where there is no acetabulum, the treatment must, of necessity, be largely a failure, and the benefit derived from the operation is only slight. This is the only ideal result I have ever seen in such cases.

### ALCOHOLIC NEURITIS, WITH REPORT OF CASE.\*

BY C. MARTIN WOOD, M. D., DECATUR.

Multiple or poly-neuritis is an inflammation of nerves limited to their peripheral distribution. All degenerative processes of nerves are not included in this term however. Babinski (1) divided the degenerative and inflammatory processes into two classes: 1st. Those depending upon lesions of nerve centres themselves, e. g. an inflammation and destruction of the anterior horn cell causes a degeneration of the corresponding motor nerve. 2d. Those in which the nerves are attacked primarily in their trunks or distributions. The term multiple neuritis is limited to the 2d class.

It is only within the last eighty years that multiple neuritis has been recognized as a distinct disease and a much shorter time has elapsed since its pathology has been demonstrated. It was first described from a clinical standpoint by James Jackson (2) in 1822. Previous to that time it had been mistaken for a spinal cord disease, doubtless because of its symmetrical distribution. Jackson's case was of the alcoholic type and while he described it very fully he attributed the paralysis to an affection of the muscles and not of the nerve centres. Dumenil was the first observer to demonstrate the true pathology of the disease in 1864.

**Etiology.** The chief cause of multiple neuritis is a blood state affecting the parenchyma of the nerves. It is well known that certain poisons have a selective action for certain parts of nerve structure. Thus curari affects the motor end plates, while

strychnine acts chiefly on the communicating fibres of the cord. A further proof of this selective action is seen in the chronic form of this disease in which fibres may be affected according to their specific function and temperature sense or pain sense be affected separately. The result is that certain nerves are affected simultaneously and symmetrically.

W. Allen Starr (3) divides the causes of multiple neuritis as follows:

I. Toxic cases due to poison from without the body. (a) Metallic. (b) Non-metallic.

II. Toxemic cases from infection.

III. Dyscrasie, as rheumatism.

IV. So-called idiopathic cases. (This class becomes smaller as our knowledge increases.)

W. A. Jones (4) reports ten cases of multiple neuritis in which the onset of disease as well as its occurrence at a time when influenza was epidemic in the city suggests that the influenza bacillus was responsible for the neuritis. The endemic form or beriberi occurring in Japan is supposed to be due to a micro-organism.

Of these causes, the toxic is the most important, and alcohol is by far the most common. It is the alcoholic type that I wish to consider here.

Alcoholic neuritis attacks persons in the prime of life, generally between 20 and 45 years, although a few cases have been reported in infants. Women seem to have a special susceptibility to the alcoholic poison and in Dana's cases there were ten females to one male affected. The steady and regular tipplers are more liable to the disease than those who indulge only periodically, and as Osler remarks the development of the neuritis may be the first intimation to the physician and family of the habit of secret drinking. Cold, exposure, or the occurrence of the infectious diseases are predisposing factors.

**Pathology.**—In neuritis due to the extension of inflammation the nerve is usually swollen, infiltrated and red in color. The inflammation may be chiefly in the parenchyma, in which case it resembles secondary degeneration from section of the nerve. The

\*Read at the 53d Annual Meeting, Quincy, May 20, 1902.



myelin becomes fragmented, granular and disappears. In the interstitial form, lymphoid elements are seen between the nerve bundles, and later connective tissue replaces the normal nerve structure.

**Symptoms.** In some cases there are premonitory symptoms of numbness and tingling in the hands and feet several weeks before the attack. In others the attack sets in abruptly with pain and weakness in the extremities, loss of knee jerk, and fever, which however is usually temporary. The pain and weakness increase and the nerves and muscles become tender and sore. The patient is unable to stand and is compelled to go to bed. The skin may become reddened and extremely sensitive so that the touch of the bed clothes cannot be borne. In a week or ten days there may be a loss of power in the anterior tibial muscles and in the extensors of the hand. In a short time atrophy of the affected muscles sets in and there is an early change in electrical reactions. There may be a partial or complete reaction of degeneration. The knee and elbow jerk are usually lost early and almost always in severe cases. Delirium is present in a large majority of the cases; either of the low muttering type or maniacal with hallucinations.

For further consideration the symptoms may be divided into: motor, sensory, trophic, visceral, and mental.

The most marked motor symptoms is paralysis of a flaccid type, which appears early, before atrophy is apparent. The anterior tibial and the extensors of the hand are affected most, but the action of the calf muscles and flexors of the hand may show some weakness. The affected muscles fail to respond to the faradic current and require a strong galvanic current to produce a contraction. The normal order of response may be changed. The knee and elbow jerk are diminished or lost. Cramps in the muscles are sometimes present for several weeks before the onset of the disease and occasions great distress. Tremor is sometimes seen; it is fine and made worse on attempting voluntary movements. As a late symptom contractures of the paralyzed limbs develop and may be extreme. Pain is the most

prominent sensory symptom. It appears early and is of a burning agonizing character. It is made worse by attempting movement and pressure over the course of the affected nerves or squeezing the muscles is extremely painful. The skin is hyperesthetic in some areas and anesthetic in others. Muscular and articular anesthesia cause a degree of ataxia which is so great in some cases that it resembles tabes.

Trophic and vaso-motor disturbance is manifested in a rapid atrophy of the affected muscles and in oedema and redness of the skin. The functions of the bladder and rectum are not interfered with to any extent. Pain in the abdomen was a marked feature of the case reported below.

A muttering delirium is the most common form of mental disturbance. There is marked confusion of time and place and the patient imagines he is in strange surroundings. The mental symptoms have the peculiarity of being worse at night. There is a loss of memory especially for recent events, and delusions growing out of this forgetfulness. Thus they may think they have to get up and go to work or attend to some business matter which has already been performed. Insomnia is present and may persist in spite of large doses of chloral and bromide. It is present even after the pain has been controlled by morphia.

**Diagnosis.** There is usually not much difficulty in diagnosing a case with acute onset. "The early loss of contraction in response to the faradic current and the diminished response to the galvanic current is quite pathognomonic of neuritis. In anterior poliomyelitis where the muscles respond to galvanism only, it does not require a strong current to cause contraction until some months after invasion." (5)

We distinguish it from tabes by the absence of the Argyll-Robertson pupil, absence of bladder and rectal disturbances and more acute onset. Romberg's symptom is absent in neuritis and the ataxia is of slight degree. Cases have been mistaken for rheumatism in the early stages but the character of the pain is different and the early paralysis and change in electrical reactions of neuritis would enable a diagnosis to be made. "Neu-

ritis is distinguished from diffuse myelitis by investigating the cause and onset. Neuritis begins more slowly and with sensory prodromata; it affects the legs and feet especially the extensors and if it ascends skips the hips and trunk and affects the forearms. There is more muscular atrophy than in myelitis. The gradual improvement of the paralysis and atrophy and eventual recovery confirms the diagnosis of neuritis." (6)

**Prognosis.** The prognosis in alcoholic cases is usually bad, not so much on account of the neuritis but by reason of the general condition of these patients. They generally die of pneumonia or some renal complication. Provided the general condition is good and the use of alcohol is discontinued they recover entirely from the paralysis in from six months to a year.

**Treatment.** The patient must be confined to bed, and the legs and arms wrapped in cotton batting. Hypodermics of morphine will be required for the pain. If there is great vital depression strychnin is indicated. In the later stages massage and friction may be used on the atrophied muscles, and exercise obtained by the interrupted current. Passive movements and extension should be used if contractures are present.

The case which I report below is peculiar in that the paralysis was confined to the upper extremity. Dercum mentions the fact that wrist drop alone might be present, and a case of this kind has been reported by Buzzard (7) and one by Ferrier (8).

**Case M. F. German.** Age 36. His father is living at the age of 83; his mother died at 73 of asthma. The patient has always been healthy and strong until two years ago. He has worked in a saloon as bartender for the past ten years. He has been accustomed to taking several glasses of beer and wine daily throughout this period. In addition he drank a small amount of whisky occasionally but did not drink to the point of intoxication. He has never worked about lead or paint. I first saw the patient in August, 1900, when he suffered with cystitis accompanied by severe abdominal pain. Under treatment he improved rapidly and

was well within ten days. On Sept. 10th after being chilled while perspiring he noticed scanty urine and abdominal pain. A urine examination showed albumin and hyalin and epithelial casts in moderate amount. He also had persistent insomnia; 30 grains of sulphonal producing no effect. Under treatment he improved and by Sept. 18th casts and albumin were absent from the urine. On June 24th, 1901, he had a very similar attack but the abdominal pain was more severe; a few casts were present in the urine but albumin was absent as was also pus. In November, 1901, he had an attack characterized by severe abdominal pain and also pain and weakness in arms and legs. There was no actual paralysis and recovery ensued in a couple of weeks. A diagnosis of neuritis was made at this time. On Jan. 13th, 1902, he again developed severe abdominal pain of the most agonizing character requiring hypodermics of morphine. The pain also affected the legs and arms and was described as of a burning and boring character. There was slight fever but it was of short duration. The skin and muscles of the arms and legs were sensitive to touch and pressure. The knee jerk and elbow jerk were diminished. Insomnia was persistent in spite of chloral and bromides. The morphine relieved the pain, but did not produce sleep. At the end of a week paralysis was noticed in the arms. He could not extend the wrists and his power of grasping articles was diminished. Tremor of the hands was noticed especially if he attempted to reach for something.

The urine was examined at this time and found normal, no albumin or casts being present. Another examination a month later showed nothing abnormal.

The pupils reacted normally to light and accommodation. At the end of ten days the wrist drop was present, the hands hanging limply when the arms were extended. The power of motion in the feet was not lost at any time and he was able to walk about the room as soon as his general condition permitted. At about this time he developed delirium at night and insisted on going out and at one time broke the window in his endeavor to get outside. In the day

time he was quite rational but could not remember events of the day before. The urine was concentrated but otherwise showed nothing abnormal. After persisting for nearly two weeks the pain became less and the patient was able to sleep more. The mental symptoms improved. At this time the extensor muscles of the hand showed no contraction when stimulated by the faradic current. It was not until two weeks later, when he was able to come to the office that they were tried with the galvanic current. The response was in the normal order *e c c* and *a o c* but required more than normal amount of current.

At the present time (April 4th.) he has fully recovered except for the wrist drop. There has been some slight improvement in the forearm muscles but atrophy is still quite marked.

#### References.

1. Babinski-Des Nevrites. *Traite de Medecine de Charcot*. Bouchard et Brissaud Paris, 1894.
2. *New Eng. Jour. of Med. & Surg.*, 1822.
3. *Medical News*, Jan. 25, 1902.
4. W. A. Jones Jour. Amer. Med. Ass'n.
5. Allen Starr. *Med. Record*, N. Y., 1887.
6. Dana. *Text-Book of Nerv. Diseases*.
7. *Brain*. Vol. II, p. 90.
8. *International Clinics*. April, 1901.

## THE PHYSICIAN AND THE ILLEGITIMATE CHILD.\*

BY HASTINGS H. HART, M. D., LL. D.

Superintendent of the Illinois Children's Home and Aid Society.

The physician, more than any other public servant, is the guardian of the sexual morals of the community. His relation to his patient is such that he is able to exercise a potent influence at the time when it is most needed. Many a man has been saved to honor and rectitude; many a young woman has been rescued from dire peril and has become a good wife and mother through the wise and timely intervention of a faithful physician. He can do what neither parents, clergyman nor friend can do. The relation of the physician to the illegitimate child is vitally important. He is invariably

consulted, sooner or later, and his advice is usually followed. A great responsibility rests upon him therefore, because he practically controls the policy of the community in dealing with this very important social question.

In considering the question of the illegitimate, four parties are to be considered: the child, the mother, the father and the community, including relatives and friends.

The first party to be considered is the child. Unfortunately, too often, the child is considered last, but rightfully it is entitled to first consideration. Whatever blame may attach to the mother, the father, the grandparents or the community, the baby is innocent. It has a right to life and to a fair start in life. It is the duty of the physician to see that the child's life and health are properly guarded before and after birth. It comes into the world often wronged before its birth. The mother has been anxious, worried, badly nourished; she has laced herself unduly to conceal her condition, or the child has been injured by efforts to produce an abortion. After birth, in many cases, the child is not put upon the breast, either because the mother does not want it or from fear lest she should become too much attached to it.

In order that the baby's life may be properly guarded the following precautions are essential: First, the mother should receive proper medical care and nursing. If physically capable, she should invariably be required to nurse the child. The young mother is often encouraged to wean her baby and board it out in some "Home" or baby farm, in order to become a wet nurse at eight or ten dollars per week; and her baby is robbed of the nourishment which rightfully belongs to it, and perhaps loses its life, in order that the baby of the more fortunate mother may be preserved. The right way is to allow the young mother to nurse her own baby as well as the foster child, supplementing the mother's milk, so far as necessary for both babies, by modified cow's milk, under the direction and prescription of the physician. Experience has proven abundantly that this method can be pursued with entire safety to both children.

\*Read at the 53d Annual Meeting, Quincy, May 20, 1902.



If it is impracticable for the mother to nurse the baby, then the feeding should be regulated by the physician. The proportions of the food should be prescribed; the child should be carefully guarded from contagion and infection which produce skin diseases, cholera infantum, etc. To this end little babies should not be congregated in any considerable number and sick babies should be carefully segregated, both for their own sake and that of others. Baby farms should be placed under rigid medical supervision, with a system of licensing. The proprietors of baby farms should not be allowed to give babies away to irresponsible people, but the placing of such children should be carefully supervised by competent state agents.

The second party to be considered is the mother of the child. The chief object to be sought is her reclamation to good character and good womanhood; and to strengthen and guard her so as to prevent a recurrence of the wrong doing. Incidentally, it is proper to take into account her feelings as a mother and to shield her, as far as may be properly done, from the shame and disgrace to which she is exposed; but it is a question how far it is right to relieve her from the natural consequences of her error. Providence has ordained certain results which are intended to deter from immorality. When a girl, through vanity or recklessness or passion, through affection or deception has been led to the commission of such a fault, if she escapes easily from the consequences, she is apt to say: "That was not so dreadful after all," and speedily the sin is repeated.

Our experience has led us to feel that it is a wholesome thing to hold the young mother to her obligation and to have her feel that it means something to bring a child into the world. If she heartlessly disregards her obligation to the child of which she is the rightful protector, crushing the natural affections of her heart, a hardening effect is instantly visible. We have known cases where such girls were found a second or third time appealing to the public for assistance in disposing of illegitimate children. When they learn that such an

ineumbrance is easily gotten rid of a great deterrent is removed.

We have been led, therefore, to follow the example of the best foundling asylums and similar institutions and to insist, whenever practicable, that the mother and child shall remain together for a period of from six months to a year. When necessary we undertake to provide for the mother with the child for that period; but we find that it is not difficult to obtain employment for a healthy young woman in a good home where she may maintain both herself and her child. The best places are usually found with good people of moderate means who cannot pay high wages, but are willing to receive the mother and child as members of the family and to treat them with consideration and tact. Unfortunately so many young married women are separated from their husbands that it does not necessarily create a presumption against a woman's character to have a young child without a visible father.

There need be no scruple about creating an affection in the mother's breast which will increase pain of parting. It is often good for her to suffer in behalf of her child. It is always good for her to feel that she has been faithful to the obligations of motherhood.

The question how long the child shall remain with the mother is one to be determined by circumstances. In cases where it is necessary for a mother to be separated from her child, it is often beneficial to encourage her to provide for the expense of handling and placing the child rather than to throw it into the arms of the charitable public; but this is a delicate matter, for it tends to create the impression that illegitimate children can be disposed of for a financial consideration, and to justify the nefarious traffic of the baby farms in human flesh. For this reason some of the best child-placing organizations refuse to receive money with such children. If they receive them at all it is without compensation from the mother or her friends.

It is the practice of the Illinois Children's Home and Aid Society, first to determine the question whether it ought to receive the child, independent of the question whether

any money is to be paid or not; second, to ascertain whether the mother, father or other friends desire to or are able to provide for the expense of receiving and placing the child. Many mothers are unwilling to make their child an object of charity and are desirous of meeting the expense, as a matter of self-respect. While the society encourages parents to meet the expense, if practicable, it will receive a child just as readily without money as with it and will refuse a child which ought not to be received just as promptly when money is offered as when it is not.

Physicians are often appealed to by young women to assist them in concealing their situation from their parents. This ought not to be done. If the girl has reputable parents she needs their counsel and assistance at this time, if ever. If she deceives them she will be compelled to heap up one lie upon another. She must account for her absence and for her expenses. It is impossible to build character upon a lie and while it is unnecessary for her to take other friends into her confidence, it is indispensable that she should do this with her parents. We are accustomed to refuse to have anything to do with such a case unless the girl will consent to confide in her parents. The cases are very exceptional where parents are unwilling to meet their obligation toward their daughter if the matter is properly presented to them.

Not infrequently it is practicable for the mother to retain the child permanently; sometimes through marriage with the father of the child; sometimes through marriage with some worthy man who, convinced of her penitence, is willing to take her and become a foster father to the child; sometimes through finding refuge in a good home where she can be sheltered, and sometimes through the co-operation of her relatives who are willing to accept responsibility for their own flesh and blood.

The third party to be considered is the father of the child. It is almost a universal rule that while he is the chief offender he suffers least of all. It is highly important that he shall be brought to face his obligation and to meet it as far as he is able. If

he goes Scot free, the chances are more than equal that he will betray other young girls. In many cases the young man himself seeks the advice of the physician before the birth of the child. He is frightened, ashamed, ready to follow the doctor's advice and to do anything in his power to right the wrong that he has committed. That is the moment of opportunity. A few weeks later he will be ready to shift the burden upon the young woman or to fly the state, leaving her to bear the shame of exposure, alone and unaided. There are a few cases where a young and foolish man is the victim of an adventuress, but those cases are the exception. Such women do not often have children. It is surprising how readily the friends of the young man lend themselves to efforts to relieve him of his obligation and just penalty. These efforts are ably seconded by the friends of the mother, with the physician, hospital authorities and nurses who, in their anxiety to protect the good name of the mother, contribute at the same time to shield the father. These conditions are still further aided by the practice of the community, which condones the offense of the man, allowing him to maintain his place in society, notwithstanding his cruel abandonment of the child and the mother, who ought to be the objects of his tender solicitude. Those who have to do with the illegitimate child fail lamentably of their duty unless an earnest effort is made to bring the father to account. In many cases a marriage should take place. If the young people love each other a happy marriage often results. Even in cases where they do not afterwards live together a marriage is sometimes desirable.

If a marriage is not practicable, the father should be persuaded or compelled, if able, to make suitable provision for the mother and child. The laws of Illinois provide that the father may be compelled, if able, to make provision up to the sum of \$550, but, in practice, comparatively few fathers are brought to make such provision. The mother is deterred from taking legal steps, sometimes on account of affection for the father, more often on account of her unwillingness to subject her own name and

that of her family to the ignominy which attends bastardy proceedings.

The very name of these proceedings carries a bitter stigma, both to herself and to her child. The young father often, through friends or through some lawyer, proposes a nominal settlement whereby she receives perhaps \$20 or \$50 instead of the \$550 to which the law entitles her.

In such cases the mother should be advised to secure the counsel and assistance of some good lawyer of mature years. Such a lawyer, by the use of vigorous pressure, can often secure some adequate provision for the mother and child without the necessity for public court proceedings. Under the vigorous handling of such a lawyer the young man can be made to bear some small share of the suffering which is incident to his wrongdoing.

If the father cannot be reached by this method, then, if possible, he should be made to feel the strong arm of the law. The mother and her friends often owe it as a duty to the community to prosecute the offender. This is true especially where he is known to have debauched other young girls or in cases where he has sought to escape the consequences of his wrongdoing by marriage with another woman.

It may be laid down as a general principle not only that the man in the case deserves punishment, but that his punishment is one of the most hopeful methods of preventing the multiplication of these sad cases.

The fourth party to be considered is the community, including the parents and friends of the offenders and the multitudes of other young people who are exposed to like temptation. In dealing with these cases we are bound to consider the effect of our action upon the community at large. What standards of morals are we establishing? What will be the effect upon other young men and women? What unnecessary burdens will be inflicted upon the community? It is peculiarly true of this form of wrongdoing that the innocent suffer with the guilty. The parents whose good name is dragged in the dust and who suffer, not only shame but agonies of anxiety for their children, are much to be pitied; yet it

must be remembered that in many cases they have a large responsibility for the results which they discover with such astonishment. Fathers who neglect to instruct their sons as to the responsibilities and dangers of young manhood; mothers who allow their daughters to go about with young men of whom they know nothing and who fail to maintain the confidence and sympathy of their daughters ought not to be too much surprised at the natural result of their shortcomings.

Be this as it may, parents have no right to turn their daughters out of doors or to send them to a distant lying-in hospital, to be subjected to maltreatment of charlatans or knaves, or perhaps to sacrifice their lives in criminal efforts to escape the consequences of wrongdoing. Still less is it right for parents to shield a son and dissuade or prevent him from following the right instinct which urges him to do a manly part toward the partner of his fault.

In all great centers of population young women flock to hide their shame and to secure hospital care. They and their infants become a burden upon the community already overtaxed, while the communities where they belong escape. They fill the maternity wards of public hospitals and physicians and professors in medical colleges wink at this because these young women afford such excellent clinical material for medical students.

I desire to say in behalf of the Illinois Children's Home and Aid Society that the services of the society are freely offered to every physician who may desire counsel or assistance in dealing with any case of illegitimacy. We do not lay down any fixed rules for dealing with such cases. We employ trained agents and we endeavor, first, to find out just what ought to be done in the particular case before us and then, if possible, to do that thing. It may be to take the child from the mother and place it in a family home; it may be to secure a situation for the mother, where she can nurse her baby and keep it with her; it may be to secure a boarding place where the mother can pay board for the child; it may be to care for the mother and child together



in a suitable institution, for six months or a year; it may be to induce the grandparents to adopt the child as their own; or it may be to bring about a marriage between the parents.

It is freely admitted that this whole subject is one beset by difficulties and one which taxes the wisdom and conscience of the wisest social student; but it rightly demands our careful study and the faithful performance of our obligations. When one contemplates the multitude of young women, timid, inexperienced, shame-faced, driven into the maelstrom of a great city by the coldness of their friends and the hostility of their native communities; when one considers the sufferings through which they pass, alone and unprotected; the perils to which they are exposed with no sufficient counsellor; the perpetual stream of these poor creatures, pouring into the houses of prostitution, to become bondwomen, doomed to a brief life of misery, and an early and forgotten grave, his heart is stirred with a desire to do some small part in redeeming them from their sad fate and restoring them to a happy and womanly life.

When one has to deal with numbers of little children who have come into life handicapped by an ill name, a weak physique and an inherited weakness of character, he feels that it is worthy of the best effort of the best science to secure for these innocent and unfortunate children those safeguards and benefits which are enjoyed by their little neighbors who are so fortunate as to be more happily born.

#### Discussion.

**C. S. Bacon**, of Chicago: I think we can all agree with the principal points of the paper just read, but I for one would make a suggestion that is in slight opposition to one of the statements made by the essayist. There is a great demand in the larger cities for good wet nurses, and these women have the opportunity of filling this demand and providing not only for their own child, but for some other child as well. I believe that this is in the interest both of the child and the mother, because she can in this way take care of her child herself and earn a livelihood besides. Again, the second child would also receive natural in place of artificial food. I think that these institutions should not give up altogether taking these children and caring for them, as they can now be cared for with very

good prospects of bringing them up well, and their mothers would help to supply a demand which is very great, more so than is usually supposed by the country practitioner. If the unfortunate mother has no means of earning a livelihood, she is naturally compelled to abandon her child or to give it in the care of some institution which finally places it and the mother loses sight of the child. These things it seems to me, should be carefully considered.

**C. B. Reed**, of Chicago: I would like to say just a word in commendation of the institution of which Mr. Hart is the superintendent, and also of similar institutions. I am connected with the Chicago Lying-In Hospital, where we have a service that consists largely of these unfortunate cases. I would like to add testimony to the beneficial results gained in very many cases as a result of sending children to such institutions as Mr. Hart represents. The results have been very satisfactory to both the mother and the child, and many of our cases are good evidence of this statement. The illegitimate child is certainly entitled to consideration and, if anything, more consideration than most people believe. These institutions are instrumental in putting the child under the care of responsible people, who will give it a good education and make it a useful and respectable member of the community.

**Dr. Hart** (closing the discussion): I should like to offer a suggestion, and that is this, that when you have occasion to consult us, we shall be very glad indeed if you consult us early. Many of these cases come to us practically decided, or perhaps the mother has already weaned the child, and we are confronted by a problem to which there is no alternative. We must either take or leave the child, and that is the reason why we cannot do as we should like in some of these cases, but must do that which is left us to do. If we could always have our way, we would get much better results. A young man came to us recently and offered me \$200.00 if we would take the child and care for it. He was the son of a wealthy farmer. Next door to this farm lived another well-to-do farmer who had a daughter. This young man had become enamored with the daughter of the other farmer, and inasmuch as the two farmers themselves were not on friendly terms, the love-making was conducted under some difficulties, and illicit intercourse was the result, and the young man came to us to help him out. In place of complying with his request, we sent our agent down to see the two farmers, with the intention of effecting a reconciliation. He saw these men and expostulated with them for some time. Finally, he succeeded in making a settlement. One of the farmers bought a piece of land in Kansas for his son, and the other farmer put up the buildings on it. The young man married the young woman and they are a very happy couple today. This is simply an illustration of what can be done when we are consulted early. I could cite many such instances. Frequently

we are at our wits' ends to know just what to do in dealing with some of these cases. We are putting as much confidence as we can in this work, and we absolutely refuse to lay down any fixed rules. We always try to do the very best we know how in order to serve the interests of the mother and the child in the best possible way. I have often found when consulting a physician that he sees the matter in an entirely different light. The young man is poor and cannot pay what the doctor asks, and he simply says he is too busy. He is sorry for the girl, and tries to get rid of the case in the easiest possible way. If, on the other hand, he came in to see us, we could get together, and with the help of the doctor we could do more good with a little more work. The results would certainly be much better in the end. We are perfectly willing at all times to learn more and to have you help us and guide us. For that reason I would have been very glad to have heard more of an expression of opinion from you in regard to this subject, which, to me, is a very vital one, and means much, especially to the poor unfortunates.

## MEMORANDA

for a

### PROPOSED ACT ESTABLISHING A BOARD OF MEDICAL EXAMINERS

in the State of Illinois.

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#### TITLE.

1	An Act, in the State of Illinois, (a)
2	for the appointment of a Board of
3	Medical Examiners in the matter of
4	state regulation. (b) and to prescribe
5	the terms of office and duties of such
6	board, (c) and for the regulation of
7	the practice of medicine and surgery in
8	all their branches, midwifery, and other
9	methods of practice, (d) and to provide
10	penalties for the violation of this
11	act, (e) and to provide for the repeal
12	of all other acts in relation thereto.
13	The People of the State of Illinois,
14	represented in the Senate and Assembly,
15	do enact as follows:

#### SECTION 1. *Appointment of Board.*

1.	There shall be a board of seven mem-
2	bers, which shall be known as the Board
3	of Medical Examiners of the State of
4	Illinois.
5	The members of said Board shall be
6	appointed by the Governor from nomi-
7	nations submitted to him by the official
8	representatives of the incorporated state
9	medical societies of the State of Illi-
10	nois.

11 Nominations may be submitted to the  
12 Governor by any State Medical Society  
13 of Illinois having an actual membership  
14 of not less than one hundred (100)  
15 resident licentiates in medicine and  
16 surgery in all their branches, as at-  
17 tested by the affidavit of its president  
18 and its secretary, provided, that any  
19 such society must embrace actual mem-  
20 bers from at least twenty different coun-  
21 ties in Illinois.

#### SECTION 2. *Terms of Office of Members.*

1 The members of this Board shall  
2 serve for seven years, except the first  
3 board, of which one shall be appointed  
4 for one year, one for two years, one  
5 for three years, one for four years, one  
6 for five years, one for six years, and  
7 one for seven years, and the successors  
8 of each for the term of seven years.

#### SECTION 3. *Organization.*

1 Said Board shall organize by electing  
2 a president, a vice-president, a secretary  
3 and a treasurer, who shall be members  
4 of the Board, and who shall hold their  
5 respective positions during the pleasure  
6 of the Board.

7 The president and the secretary of  
8 the Board shall have power to adminis-  
9 ter oaths.

10 The Board shall have power to take  
11 testimony in all matters relating to its  
12 duties.

#### SECTION 4. *Salaries.*

1 The secretary shall receive a salary  
2 to be fixed by the Board, and his neces-  
3 sary expenses in performing his official  
4 duties.

5 The other members of the Board  
6 shall each receive, not to exceed ten  
7 (10) dollars per day for the time em-  
8 ployed in the discharge of their duties,  
9 and their necessary expenses while en-  
10 gaged therein.

11 The treasurer shall give a bond in  
12 the sum of five thousand (5,000) dol-  
13 lars, with surety approved by the Board,  
14 for the faithful discharge of his duties.

#### SECTION 5. *Seal—Rules.*

1 The Board shall adopt a seal and

2 shall formulate all rules necessary to  
3 govern its actions.

#### SECTION 6. *Meetings.*

1 The Board shall meet and hold ex-  
2 aminations quarterly at such places as  
3 the Board may appoint, and may meet  
4 or hold examinations at such other  
5 times and places as the Board may ap-  
6 point.

#### SECTION 7. *Notice of Meetings.*

1 Due notice of all meetings of the  
2 Board for the purpose of holding ex-  
3 aminations shall be given by publication.

#### SECTION 8. *Record of Proceedings.*

1 Said Board shall keep an official  
2 record of its proceedings, including a  
3 register of all applicants for certificates  
4 under this act, with the result of each  
5 application. Such record shall be open  
6 for public inspection at all times and  
7 shall be published quarterly by said  
8 Board.

#### SECTION 9. *Requirements.*

1 No person, unless previously regis-  
2 tered and legally authorized, as defined  
3 by Section twenty-five (25) of this act,  
4 shall practice medicine and surgery in  
5 any of their branches, or midwifery, or  
6 other methods of treating human ail-  
7 ments, in the State of Illinois, after  
8 Jan. 1, 1904, without first applying for  
9 and obtaining a license from the State  
10 Board of Medical Examiners.

#### SECTION 10. *Applications—Medicine and Surgery in all their Branches.*

1 The applicant who desires to prac-  
2 tice medicine and surgery in all their  
3 branches shall file with the secretary  
4 of the Board his diploma and a regular  
5 application, in writing, on a form pre-  
6 scribed by the Board, verified by oath,  
7 and accompanied by the fees hereinafter  
8 specified, and furnish satisfactory proof  
9 that the applicant is more than twenty-  
10 one (21) years of age, is of good moral  
11 character, has received a sufficient pre-  
12 liminary education, as may be determin-  
13 ed by the Board, and has the degree of  
14 Doctor of Medicine granted by some



15 legally chartered medical college or in-  
16 stitution in good standing, as may be  
17 determined by the Board.

18 The applicant must accompany such  
19 diploma with an affidavit stating that the  
20 applicant is the lawful possessor of the  
21 same, and that the diploma or license  
22 was procured in the regular course of  
23 instruction and examination, without  
24 fraud or misrepresentation of any kind.

25 In addition to such affidavit, said  
26 Board may require such further evi-  
27 dence as, in its discretion, it may deem  
28 proper as to any of the matters em-  
29 braced in said affidavit.

#### SECTION 11. *Applications—Midwifery.*

1 The applicant who desires to practice  
2 midwifery only shall file with the secre-  
3 tary of the Board a regular application  
4 on a form prescribed by the Board,  
5 verified by oath and accompanied by  
6 the fees hereinafter specified, and shall  
7 furnish satisfactory proof that the ap-  
8 plicant is over twenty-one (21) years  
9 of age, is of good moral character, has  
10 received a sufficient preliminary educa-  
11 tion, as may be determined by the  
12 Board, and has devoted sufficient time  
13 to the study of midwifery, as may  
14 be determined by the Board.

#### SECTION 12. *Applications—Other Methods.*

1 The applicant who desires to practice  
2 any other method or system of treating  
3 human ailments without using any drug  
4 or appliance internally or externally,  
5 or performing any surgical operation,  
6 shall file with the secretary of the Board  
7 a regular application on a form pre-  
8 scribed by the Board, verified by oath,  
9 and accompanied by the fees hereinafter  
10 specified, and shall furnish satisfactory  
11 proof that the applicant is more than  
12 twenty-one (21) years of age, is of good  
13 moral character, has received a sufficient  
14 preliminary education, as may be deter-  
15 mined by the Board, and has devoted  
16 a sufficient period of time to systematic  
17 and regular study of the organs and  
18 functions of the human body, as may  
19 be determined by the Board.

#### SECTION 13. *Examinations—General.*

1 If the Board shall find that an appli-  
2 cant has proper credentials, it shall ad-  
3 mit such applicant to an examination.

4 All examinations shall be conducted  
5 under rules formulated by the Board,  
6 and shall be practical in character, and  
7 designed to discover the applicant's fit-  
8 ness to practice medicine and surgery  
9 in all their branches, or midwifery, or  
10 other method of practice.

#### SECTION 14. *Examinations in Medicine and Surgery in all their Branches.*

1 The examinations of those who de-  
2 sire to practice medicine and surgery  
3 in all their branches shall be conducted  
4 under the rules formulated by the  
5 Board, and shall be on the following  
6 subjects: Anatomy, physiology, patho-  
7 logy, bacteriology, chemistry, toxicology,  
8 the cause, origin and diagnosis of dis-  
9 ease, surgery, obstetrics, hygiene and  
10 sanitary science, and such other sub-  
11 jects as the Board may determine.

#### SECTION 15. *Examinations in Midwifery.*

1 The examination of those who desire  
2 to practice midwifery only shall be of  
3 such a character as to determine the fit-  
4 ness of the applicant to practice mid-  
5 wifery only, as may be determined by  
6 the Board.

#### SECTION 16. *Examinations in Other Methods.*

1 The examination of those who desire  
2 to practice any other method or sys-  
3 tem of treating human ailments, who  
4 do not use any medicine or appliance  
5 internally or externally, and who do not  
6 practice operative surgery, shall be of  
7 a character sufficiently strict to test  
8 their qualifications as practitioners, as  
9 may be determined by the Board.

(The following, while no part of the pro-  
posed Bill, is inserted for the information  
it contains.)

1 The Supreme Court of the State of  
2 Illinois said, only a few weeks ago, in  
3 reversing the decision of the people of  
4 the State of Illinois vs. Jos. P. Gor-  
5 don, "We all agree that the objects and

6 purposes of this and similar statutes  
 7 (referring to the Medical Practice Act  
 8 of 1899, Ed.) are to protect the sick  
 9 and suffering, and the community at  
 10 large, against the ignorant and un-  
 11 learned who hold themselves out as  
 12 being possessed of peculiar skill in the  
 13 treatment of disease; from holding  
 14 themselves out to the world as physi-  
 15 cians and surgeons without having ac-  
 16 quired any knowledge whatever of the  
 17 human system or the diseases and ail-  
 18 ments to which it is subject. Without  
 19 some knowledge of the location and of-  
 20 fices of the various nerves, muscles  
 21 and joints, the manipulation of those  
 22 parts and the flexing of the limbs can  
 23 not be intelligently, if, indeed, safely  
 24 practiced. Merely giving massage treat-  
 25 ment or bathing a patient is very differ-  
 26 ent from advertising one's business or  
 27 calling to be that of a doctor or physi-  
 28 cian, and as such, administering osteo-  
 29 pathic treatment. The one properly  
 30 falls within the profession of a trained  
 31 nurse, while the other does not.

32 We think the circuit court erred in  
 33 instructing the jury to find for defend-  
 34 ant, and that the Appellate Court erred  
 35 in affirming that judgment. Judgment  
 36 reversed and remanded."

#### SECTION 17. *License to Practice.*

1 If an applicant presents proper cre-  
 2 dentials, as herein specified, passes an  
 3 examination satisfactory to the Board,  
 4 and has complied with all its rules and  
 5 regulations, and has paid all fees, as  
 6 hereinafter provided, the Board shall  
 7 issue its certificate signed by at least  
 8 a majority of its members and attested  
 9 by its secretary under seal of the Board.

10 Such certificate, when left with the  
 11 county clerk for record, as hereinafter  
 12 required, shall be conclusive evidence  
 13 that its owner is entitled to practice  
 14 medicine and surgery in all their  
 15 branches, or midwifery, or other method  
 16 or system of treating human ailments,  
 17 as the case may be, in the State of Illi-  
 18 nois.

19 The examination papers shall form

20 part of the records of said Board, and  
 21 shall be kept on file by the secretary.

#### SECTION 18. *Provisions.*

1 Provided, that only those who are  
 2 authorized to practice medicine and  
 3 surgery in all their branches shall use  
 4 the title of M. D., physician, doctor or  
 5 doctress.

6 Provided further, that those who are  
 7 authorized to practice midwifery only,  
 8 shall not attend other than cases of  
 9 labor, nor use any drug or medicine, ex-  
 10 cept such antiseptic drug as may be nec-  
 11 essary to cleanse the hands of the mid-  
 12 wife and external parts of the patient.

13 Provided, that those who are au-  
 14 thorized to practice other methods can  
 15 not use any medicine or appliance in-  
 16 ternally or externally or perform any  
 17 surgical operation.

18 Such license shall be in such form  
 19 as may be determined by the Board,  
 20 and in accordance with the provisions  
 21 of this act, provided, however, that any  
 22 willful violation on the part of an ap-  
 23 plicant of any of the rules and regu-  
 24 lations of the Board governing ex-  
 25 aminations shall be sufficient cause for  
 26 the Board to refuse to issue a license  
 27 to such applicant.

28 Such certificates shall be signed by  
 29 a majority of the Board, and attested  
 30 by the secretary.

#### SECTION 19. *Certificates of Other Boards.*

1 Said Board may, in its discretion,  
 2 accept and register, upon payment of  
 3 the examination and registration fees,  
 4 and without examination of the appli-  
 5 cant, any certificate which shall have  
 6 been issued to him after examination  
 7 by the medical examining board of the  
 8 District of Columbia, or of the army,  
 9 or navy, or marine hospital service, or  
 10 of any state or territory of the United  
 11 States or its insular possessions, or any  
 12 national board of medical examiners  
 13 which may be hereafter constituted,  
 14 provided, however, that in the opinion  
 15 of this Board, the legal requirements  
 16 of any such medical examining board  
 17 shall have been, at the time of the is-

18 suing to an applicant of such certifi-  
19 cate, in no degree or particular less  
20 than those of the State of Illinois at  
21 the same time and date.

#### SECTION 20. *Examination Fees.*

1 Fees for examination and for a cer-  
2 tificate shall be as follows: Twenty  
3 (20) dollars for each examination in  
4 medicine and surgery in all their  
5 branches and five (5) dollars for a  
6 certificate, if issued; ten (10) dollars  
7 for each examination in midwifery and  
8 five (5) dollars for a certificate, if  
9 issued; for practitioners of other  
10 methods, twenty (20) dollars for each  
11 examination and five (5) dollars for a  
12 certificate, if issued, which shall be paid  
13 by the applicant to the secretary of the  
14 Board, and by said secretary to the  
15 treasurer of the Board.

#### SECTION 21. *Certificate to be Recorded.*

1 Every person holding a certificate  
2 from the State Board of Medical Ex-  
3 aminers shall have it recorded in the  
4 office of the clerk of the county in which  
5 he resides within three months from its  
6 date, and the date of the recording  
7 shall be endorsed thereon.

8 Until such certificate is recorded  
9 as herein provided, the holder thereof  
10 shall not exercise any of the rights or  
11 privileges conferred therein.

#### SECTION 22. *Removal to Another County.*

1 Any person removing to another  
2 county to practice shall record his cer-  
3 tificate in like manner in the county  
4 to which he removes, and the holder  
5 of the certificate shall pay to the county  
6 clerk the usual fee for making the  
7 record.

#### SECTION 23. *County Clerk's Book.*

1 The county clerk shall keep in a  
2 book, provided for the purpose, a com-  
3 plete list of the certificates recorded  
4 by him, with the date of the record,  
5 and said book shall be open to public  
6 inspection during his office hours.

#### SECTION 24. *Definition.*

1 Any person shall be regarded as  
2 practicing medicine, within the mean-

3 ing of this act, who shall treat or pro-  
4 fess to treat, operate on or prescribe  
5 for any physical ailment or any phy-  
6 sical injury to or deformity of another,  
7 Provided, that nothing in this section  
8 shall be construed to apply to the ad-  
9 ministration of domestic or family  
10 remedies in cases of emergency, or to  
11 the laws regulating the practice of  
12 dentistry or of pharmacy. And this  
13 act shall not apply to surgeons of the  
14 United States army, navy, or marine  
15 hospital service in the discharge of their  
16 official duties.

#### SECTION 25. *Previous Registration*

1 Any person who holds a certificate  
2 from the State Board of Health here-  
3 tofore existing under the provisions of  
4 "An act to create and establish a State  
5 Board of Health in the State of Illi-  
6 nois," approved May 29, 1877, and in  
7 force July 1, 1877, under the statutes  
8 of Illinois; or under "An act to regu-  
9 late the practice of medicine in the  
10 State of Illinois," approved June 16,  
11 1887, and in force July 1, 1887; or  
12 under "An act to regulate the practice  
13 of medicine in the State of Illinois and  
14 to repeal an act therein named," ap-  
15 proved April 24, 1899, and in force  
16 July 1, 1899, shall be entitled to prac-  
17 tice medicine and surgery in this State  
18 the same as if it had been issued under  
19 this act, but all such certificates may be  
20 revoked for unprofessional conduct in  
21 the same manner and upon the same  
22 grounds as if they had been issued un-  
23 der this act.

#### SECTION 26. *Penalty for Practicing With- out License.*

1 Any person practicing medicine or  
2 surgery in all their branches, or mid-  
3 wifery, or other methods of treating  
4 human ailments in this state without  
5 a certificate issued by this Board in  
6 compliance with the provisions of this  
7 act, or any itinerant vender vio-  
8 lating the provisions of Section  
9 thirty-one (31) of this act, shall  
10 for each and every instance of such  
11 practice or violation forfeit and pay to



the People of the State of Illinois, for the use of the said Board of Medical Examiners, the sum of one hundred (100) dollars for the first offense, and two hundred (200) dollars for each subsequent offense, the same to be recovered in an action of debt before any court of competent jurisdiction, and any person filing or attempting to file as his own the diploma or certificate of another, or a forged affidavit of identification, shall be guilty of a felony, and upon conviction shall be subject to such fine and imprisonment as are made and provided by the statutes of this State for a crime of forgery. Provided, that this section shall not apply to physicians who hold unrevoked certificates from the State Board of Health issued prior to the time of the taking effect of this act.

**SECTION 27. *Unprofessional or Dishonorable Conduct—Board may withhold or Revoke Certificates—Hearing.***

The State Board of Medical Examiners may refuse to issue the certificates provided for in this act to individuals who have been convicted of the practice of criminal abortion, or who have by false or fraudulent representation, obtained or sought to obtain practice in their profession, or by false or fraudulent representation of their profession have obtained or sought to obtain money or any other thing of value, or who advertise under names other than their own, or for any other unprofessional or dishonorable conduct, and the Board for like causes may revoke such certificates and those issued under the provisions of previous acts. Provided, that no certificate shall be revoked or refused until the holder or applicant shall be given a hearing before the Board.

**SECTION 28. *Definition of Unprofessional Conduct.***

The words "unprofessional conduct," as defined in this act, are hereby declared to mean:

1st—The procuring or aiding or

abetting in procuring a criminal abortion.

2d—Any advertising to the public of medicines, or of means, whereby the monthly periods of women can be regulated, or the menses re-established, if suppressed.

3d—The obtaining of any fee on the assurance that a manifestly incurable disease can be cured, or by other deceptive measures.

4th—The willfully betraying a professional secret.

5th—Conviction of any offense involving moral turpitude.

6th—Habitual intemperance.

7th—Any act derogatory to the morals or standing of the medical profession or injurious to the public as may be determined by the Board.

**SECTION 29. *Fraudulent Representation of Practitioners.***

That it shall be unlawful for any physician or other person to practice medicine in this state in the name of another physician, or to hold himself out as such other physician by advertisements, bills, posters or otherwise, for the purpose of imposing upon or defrauding any other person. It shall be unlawful for any person not licensed by the State Board of Medical Examiners of Illinois to practice medicine and surgery in all their branches, to act as the representative of or distributor of medicines for any physician not resident of Illinois.

Any person who shall violate either of these provisions of this act shall be subject to a fine of not less than five hundred (500) dollars for the first offense, and imprisonment for a period of six months in the county jail of the county in which the offense is committed for each offense committed thereafter.

It shall be the duty of the State's attorney in each county of Illinois to prosecute all persons violating any of the provisions of this section.

SECTION 30. *False Representation.*

1 Any person not duly appointed and  
2 fully authorized, assuming to act as a  
3 member, officer or representative of the  
4 State Board of Medical Examiners  
5 shall be guilty of a felony, and shall be  
6 punished by a fine of not less than  
7 one hundred (100) dollars, nor more  
8 than five hundred (500) dollars, or by  
9 imprisonment in the county jail for a  
10 term of not less than sixty (60) days  
11 nor more than one hundred and eighty  
12 (180) days, or by both such fine and  
13 imprisonment.

14 It shall be the duty of the State's  
15 attorney in each county of Illinois to  
16 prosecute all persons violating any of  
17 the provisions of this section.

SECTION 31. *Itinerant Venders—License and Penalties.*

1 That any itinerant vender of any  
2 drug, nostrum, ointment or appliance  
3 of any kind intended for the treatment  
4 of disease or injury, who shall, by writ-  
5 ing or printing, or any other method,  
6 profess to the public to cure or treat  
7 disease or deformity by any drug, nos-  
8 trum or application, shall pay a license  
9 of one hundred (100) dollars per month  
10 into the treasury of the Board, to be  
11 collected by the Board in the name of  
12 the People in the State of Illinois, for  
13 the use of said Board. And it shall  
14 be lawful for the State Board of Medical  
15 Examiners to issue such license on ap-  
16 plication made to said Board, such  
17 license to be signed by the president  
18 and a majority of the members of the  
19 Board and attested by the secretary with  
20 the seal of the Board, but said Board  
21 may, for sufficient cause, refuse such  
22 license. And such itinerant vender,  
23 who shall, by writing or printing, or  
24 any other method, profess to cure or  
25 treat disease or deformity by any drug,  
26 nostrum or appliance without a license  
27 so to do, shall be deemed guilty of a  
28 violation of this section, and upon con-  
29 viction shall be subject to the penalties  
30 hereinafter provided.

SECTION 32. *Enforcing Penalties—Appeals.*

1 Upon conviction of any of the offenses  
2 mentioned in this act, except in Section  
3 29 and 30, the court shall, as a part of  
4 the judgment, order that the defendant  
5 be committed to the common jail of  
6 the community until the fine and costs  
7 are paid, and upon failure to pay the  
8 same immediately, the defendant shall  
9 be committed under said order for first  
10 offense not more than ninety (90) days.

11 Provided, that either party may ap-  
12 peal in the same time and manner as  
13 appeals may be taken in other cases,  
14 except that where an appeal is prayed  
15 in behalf of the people, no appeal bond  
16 shall be required to be filed, whether  
17 the appeal be from the justice of the  
18 peace or from the county or circuit  
19 courts, or from the appellate court.  
20 But it shall be sufficient in behalf of  
21 the People of the State of Illinois, for  
22 the use of the State Board of Medical  
23 Examiners, to pray an appeal, and there-  
24 upon appeal may be had without bond  
25 or security.

SECTION 33. *Board to Make Report of Proceedings and Pay all Funds into State Treasury.*

1 On the 30th day of September of  
2 each year the State Board of Medical  
3 Examiners shall make report of its pro-  
4 ceedings, to the Governor and the pub-  
5 lic, showing all items of receipts from  
6 all sources and disbursements for all  
7 purposes, and all funds in the treasury  
8 on said date which shall have been  
9 received in the enforcement of this act  
10 shall be paid into the state treasury.

SECTION 34. *Repeal.*

1 All acts and parts of acts inconsistent  
2 with this act are hereby repealed.

## SECTION 35.

1 This act shall be in force on and after  
2 the first day of January, 1904.

The following, while not framed by the  
Legislative Committee, was presented by the  
Chairman for the consideration of the meet-  
ing, and was unanimously endorsed and rec-  
ommended to the meeting of the State So-  
ciety:

## MEMORANDA FOR

AN ACT to Promote better Training of Physicians, and more careful attention to the sick in all Public Institutions in the State of Illinois.

Whereas, Public policy as well as private interest demands that the sick shall receive the most skillful and humane treatment; and

Whereas, The greatest skill by physicians can only be obtained by careful clinical study; and

Whereas, The most humane treatment will be given by the most skillful and best educated physicians; and

Whereas, It has often been shown that charity patients who are the subjects of special study by students and physicians, receive the best treatment; therefore, every practicable facility should be afforded physicians and medical students in this State for thorough clinical study of diseases. To this end

*Be it enacted by the People of the State of Illinois*, that the officers in the State or any of its counties or townships who are in charge of any public institution that is supported wholly or in part of the State, county, city or town taxes shall furnish every practicable opportunity to students or physicians for the study of diseases occurring in the inmates of such institutions.

Such clinical study shall be conducted under regulations to be prescribed by the medical and surgical officers (or staff) of each institution.

Only such physicians and surgeons shall be appointed to these institutions as are known to be skillful and humane, and capable of directing and willing to provide opportunities for thorough clinical study to such physicians and students as may desire to avail themselves of the opportunity.

Physicians and medical students who conform to the rules and regulations prescribed by the medical and administrative officers shall be admitted to these institutions for clinical study and instruction upon payment of moderate fees similar to the fees that are usually charged for like facilities in other states. The money received from said fees shall be covered into the treasury of the

State or the county, city or town interested in the support of such institution, for the purpose of aiding in defraying any expense incident to such instruction or study.

No medical officer of any such institution shall receive a salary from the public for giving such instruction or providing for such study, or any fee or gratuity from the students or physicians taking such clinical study or instruction, it being the intent that any profit derived from this work shall accrue to the benefit of the institution.

Such clinical study and instruction shall conform to the sanitary rules of the State Board of Health and shall be under its supervision. The State Board of Health shall have authority to inspect such institutions at all times and it shall be their duty to report the conditions found to the appointing body. Failure on the part of any of the officers of administration or of the medical officers to provide proper facilities for the careful study of the patients under suitable regulations, shall be reported by said Board to the appointing body and upon satisfactory proof of such failure, the person or persons responsible therefor, shall be removed by the appointing body and their places supplied by those who will carry out the intent of this act.

(Here provide a paragraph of whatever form may be necessary to secure the enforcement of this act, not only to administrative and medical officers of each institution, but also by the appointing body.)

## NEW INCORPORATIONS.

The Secretary of State at Springfield has licensed the following corporations:

Harvard institute, Chicago; for instruction in psychic phenomena; incorporators, Arthur G. Hulbert, Elwyn C. Hulbert, and Levi S. Lewis.

The Osteopathic Publishing company, Chicago; capital \$20,000; printing and publishing; incorporators, J. W. Cecil, Henry S. Bunting, and J. S. Grant.

The Sulpho Remedy company, Chicago; capital, \$10,000; manufacturing druggist sundries; incorporators, Edgar A. Porter, Charles A. Koepke, and Edward R. Austin.

The Bell Medical company, Chicago; capital, \$20,000; manufacturing medical preparations; incorporators, Alonzo M. Wheeler, Earl Brownell, and Pearle B. Wheeler.

The College of Medicine and Surgery, Chicago, certifies to decrease in capital stock from \$50,000 to \$8,000.



# The Illinois Medical Journal.

The Official Organ of the State Medical Society.

EDITOR—George N. Kreider, A. M., M. D., Springfield.

Official Reporters of Affiliated Societies—

## COUNTY SOCIETIES.

Adams County—Henry Hart, M. D., Quincy.  
Alexander County—J. T. Walsh, M. D., Cairo.  
Bureau County—H. E. Owens, M. D., Princeton.  
Bond County—W. T. Easley, Greenville.  
Carroll County—H. S. Metcalf, M. D., Mt. Carroll.  
Champaign County—A. S. Wall, M. D., Champaign.  
Calhoun County—T. O. Hardesty, M. D., Kampsville.  
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Crawford County—L. J. Weir, M. D., West York.  
Douglas County—W. E. Rice, M. D., Tuscola.  
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Johnson County—J. E. McCall, M. D., Vienna.  
Kankakee County—Henry H. Rogers, M. D., Kankakee.  
Kendall County—R. A. McClelland, M. D., Yorkville.  
La Salle County—R. A. Pike, M. D., Ottawa.  
Lake County—A. G. Haven, M. D., Lake Forest.  
Livingston County—Jno. Ross, M. D., Pontiac.  
McDonough County—R. E. Lewis, M. D., Macomb.  
Macoupin Co.—J. Palmer Matthews, M. D., Carlinville.  
McLean County—E. S. Reedy, M. D., Bloomington.

## DISTRICT SOCIETIES.

Aesculapian—H. McKennan, M. D., Paris.  
Brainerd District—J. L. Lowrie, M. D., Lincoln.  
Central Illinois—F. J. Eberspach, M. D., Pana.  
Galva District—C. W. Hall, M. D., Kewanee.  
Fox River Valley—H. J. Gahagan, M. D., Elgin.  
Military Tract—C. B. Horrell, M. D., Galesburg.  
North Central—Geo. A. Dicus, M. D., Streator.  
Southern Illinois—O. B. Ormsby, M. D., Murphysboro.  
Tri-County—Leroy Jones, M. D., Hoopeston.

## URBAN SOCIETIES, EX CHICAGO.

Alton Medical Society—Geo. E. Wilkinson, M. D., Alton.  
Decatur Medical—C. Martin Wood, M. D.  
East St. Louis—C. W. Lillie, M. D.  
Jacksonville Physician's Club—D. W. Reid, M. D.  
Peoria Medical—E. M. Eckard, M. D.

All communications should be addressed to the Editor, 522 Capitol Ave., Springfield, Illinois.

The Society does not assume responsibility for any statements or opinions published in the JOURNAL.

The JOURNAL is published monthly. The subscription price is \$3.00 per annum in advance. The JOURNAL is furnished free to the members of the Society.

Entered at the postoffice in Springfield as second class matter.

Marshall County—W. G. DuFour, M. D., Henry.  
Massac County—C. E. Trovillion, M. D., Metropolis.  
Mercer County—A. N. Mackey, M. D., Aledo.  
Montgomery County—J. M. Trigg, M. D., Farmersville.  
Morgan County—T. A. Wakely, M. D., Jacksonville.  
Knox County—G. S. Brown, M. D., Galesburg.  
Ogle County—H. A. Mix, M. D., Oregon.  
Perry County—J. W. Smith, M. D., Pinckneyville.  
Pike County—R. H. Main, M. D., Barry.  
Pope County—W. S. Dixon, M. D., Rosebud.  
Pulaski County—Chas. J. Boswell, M. D., Beechwood.  
Rock Island Co. Ass'n—Jos. DeSilva, M. D., Rock Island.  
Saline County—J. K. Baker, M. D., Harrisburg.  
Sangamon County—F. B. Fisher, M. D., Springfield.  
Schuyler County—A. W. Ball, M. D., Rushville.  
Shelby County—A. G. Mizell, M. D., Shelbyville.  
Stark County—M. T. Ward, M. D., Toulon.  
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Vermilion County—E. E. Clark, M. D., Danville.  
Wabash County—J. B. Maxwell, M. D., Mt. Carmel.  
Warren County—Adella R. Nichol, M. D., Monmouth.  
White County—W. A. Steele, M. D., Carmi.  
Will County—Herbert S. Worthley, M. D., Joliet.  
Williamson County—G. W. Evans, M. D., Marion.  
Winnebago County—S. R. Catlin, M. D., Rockford.

## CHICAGO SOCIETIES.

Academy of Medicine—J. G. Kiernan, M. D.  
Electro-Medical—Richard H. Street, M. D.  
German—Karl Doepfner, M. D.  
Gynaecological—C. S. Bacon, M. D.,  
Medical Society—F. X. Walls, M. D.  
Medico Legal—N. S. Davis, Jr. M. D.  
Neurological—C. H. Lodor, M. D.  
Ophthalmic and Otolological—Brown Pusey, M. D.  
Orthopedic—Edwin W. Ryerson, M. D.  
Pathological—Geo. H. Weaver, M. D.  
Physician's Club—L. H. Mettler, M. D.  
Laryngological and Climatological—J. E. Rhodes, M. D.  
Rush College—J. B. Herrick, M. D.  
Society of Internal Medicine—Robt. B. Preble, M. D.  
Southwestern—Thos. J. McGonagle, M. D.  
Surgical—D. N. Eisendrath, M. D.  
West—Gustavus M. Blech, M. D.

AUGUST 1902.

## PRINCIPAL FEATURES.

The principal features of the issue are; the proposed act establishing a Board of Medical Examiners, page 140.

The leading articles including an interesting discussion on Neuritis, which occurred at a joint meeting of the Chicago Medical Society and the Chicago Neurological Society.

Finally the advertisements which should always be read.

## AMERICAN MEDICAL JOURNALS.

Another State Society, Michigan, shows symptoms of modern activity. At its meeting in June that organization abandoned its old constitution, adopted the model recommended by the American Medical Association, and arranged to issue its transactions in monthly journal form. Thus one by one the large state societies are adopting the journal idea, the only plan by which the profession can emancipate itself from

the lethargy prevailing in its ranks and put to rout those commercial schemers who use medical publications for their own private gain.

\* \* \* \*

It is folly to suppose that the profession will continue to support trade organs of the most pronounced type masquerading as exponents of scientific thought. Many of our members refuse to give table space to certain intrusive journals of this class which seem to maintain their existence only by preying on the long suffering advertiser or by exploiting preparations in which the editor is himself primarily interested.

\* \* \* \*

One of the worst examples of this latter type is issued from St. Louis, the city which has been for a long time the Mt. Pelee of medicine. The editor, after having accumulated several millions from the credulous members of the profession, is said to have built himself a palace on Fifth avenue, New York. Altogether the worst feature of this particular publication is the influence which it wields in its editorial columns against such beneficent therapeutic measures as the serum therapy of diphtheria and vaccination for smallpox and against the germ theory of disease. Time and again have we known practitioners who quoted this journal as an authority for their opposition to these measures. As the journal is scattered gratis over the country, it is widely read and is often the only medical pabulum obtained by hundreds. How it is able to evade the postal laws is a mystery as we have never known a practitioner who has paid for it.

\* \* \* \*

That there will be remarkable changes in the number and conduct of medical publications in the next few years must be apparent to the most superficial observer. As a matter of history it may be interesting to

briefly review the condition of medical journalism in the United States at the beginning of the 20th century.

The last edition of Polk's Directory gives the number of medical journals of all classes as 280. Of these we find 21 are homeopathic, 8 eclectic and 1 physio-medical. Elijah Dowie's Leaves of Healing fails to get a place, as does Mother Eddy's publication.

\* \* \* \*

The journals of the irregular brethren do not reach publication oftener than once a month. If there is a high grade journal in the entire list it has not been brought to our notice. Modern intelligence demands the survival of the fittest here as elsewhere. That they will all gradually pass into oblivion is a foregone conclusion. The high grade weekly publications of the regular press have hundreds of irregular subscribers, and this probably largely accounts for the decadence of the sects.

\* \* \* \*

Eliminating the 30 irregular publications we have 250 regular publications. Nine of these are issued weekly, 3 in New York, 2 in Philadelphia, one in Boston, one in Cincinnati, one in Chicago (Journal of the A. M. A), and one in St. Louis. Seven appear biweekly. The remainder appear monthly as a general rule.

\* \* \* \*

In Illinois there are 28 monthly or quarterly medical publications, all except three being issued from Chicago. The three outside of Chicago in order of age are the Peoria Medical Journal, founded in 1897, but the successor we believe of the Peoria Medical Monthly founded in 1880. The Journal of the Morgan County Medical Society, founded in 1896. The Illinois Medical Journal, founded July, 1899.

\* \* \* \*

The Chicago monthlies include several high class journals, such as the Medical

Standard, in its twenty-fifth volume, the Chicago Medical Recorder, the official organ of the Chicago Medical Society, in its twenty-second volume, and the Clinical Review, in its twelfth volume. Monthlies are issued by or in connection with the leading medical schools. The National Medical University issues a journal which it dubs the Chicago Pan-Path, expressive of the hybrid education to be obtained at this institution. Another institutional organ, Suggestion, is issued by a school of Psychology. Surgery, Medicine and Psychology is the title of another journal of this class. There are two journals of ophthalmology, one of pathology, one of hydrotherapy, two of alkaloidal therapy, one of electro therapeutics, and one of railway surgery. There are five homeopathic and one eclectic journal.

\* \* \* \*

Finally there are the following five curious publications: Deutsche Americanische Natur Arzt, the editor of which bears a German name, was graduated at the Chicago National University in 1896, and is evidently one of the natural healers so common in the fatherland; the Journal of the American Animal Therapy Association, which we suggest should be printed on the Rocky mountains where the goats come from; the Journal of Diagnosis and Climatology, about which we can learn nothing; the Union Medical Journal, anti-vaccinationist, and edited by the venerable Jacobin T. A. Bland; and finally there is listed in Polk a journal called New Thought, edited by one Sydney Flower, who figured recently in the courts in a divorce suit and who seems to be an osteopath, as he appears to be the founder of a correspondence school of that school. Messrs. Polk would do well to leave out such publications in their future lists.

Mention has already been made of the Journal of the American Medical Association, which is issued weekly from Chicago, and is probably the largest and best medical publication in the world. This journal was founded in 1883, and is an excellent example of what the organized profession in America can accomplish.

\* \* \* \*

What the Journal of the A. M. A. has done for the national association the State journals can accomplish for the State Societies. The states are beginning to recognize this and we believe that medical journalism in the near future will be altogether in their hands. Pennsylvania was the first to take up the plan of publishing its transactions in monthly journal form. Its journal is ably edited by Adolph Koenig of Pittsburg, who is still proprietor of the journal. Its advertising columns are absolutely clean and speak volumes in credit of Dr. Koenig, who is dependent upon them for a part of his remuneration. Such unselfish men as Koenig are rare and Pennsylvania is indeed fortunate in possessing such a man. Under the influence of this journal the Pennsylvania Society has increased the membership of its local societies from 2,200 to 3,500. When the new constitution is adopted in September they will all become members of the State Society, making it the second in size in the Union.

\* \* \* \*

The second state to adopt the journal idea and the first to actually own its journal was Illinois. What the journal has been the means of accomplishing in three years is so well known to nearly all our readers that we mention only that where the membership three years ago was 450 it is now 3,650. This places the Illinois Society as the largest State organization in the world.

\* \* \* \*

The third state to adopt the journal was



the New York State Association. Because of the unfortunate condition prevailing in that state this journal does not appear to have made as much progress as was expected. When matters are smoothed out in that state that journal will be a great feature of the Society work.

\* \* \* \*

The fourth state to adopt the journal idea was Kansas. Concerning this journal and its influence we know little. Kansas is a great and growing state and no doubt the journal idea will thrive there.

\* \* \* \*

As before stated Michigan is about to take up this idea and we wish her the best of success in the new enterprise.

\* \* \* \*

This notice would not be complete were we to omit to mention that four county societies in four different states publish journals of great value. These are the Brooklyn Medical Journal founded in 1886, and published monthly by the Kings county (N. Y.) Medical Society; the Providence Medical Journal founded in 1899, and published bi-monthly by the Providence (R. I.) Medical Association; the St. Paul Medical Journal founded in 1898 and published monthly by the Ramsey County (Minn.) Medical Society, and finally the Journal of the Morgan County (Ill.) Medical Society, already mentioned.

\* \* \* \*

In conclusion we may be permitted to express the belief that the day of medical journalism in America is just beginning and that the honorable medical organizations will have an increasing representation and influence through them in the future.

#### NEW SUPERINTENDENT AT JACKSONVILLE HOSPITAL FOR THE INSANE.

We are glad to call attention to a recent act of Governor Yates in which we think he has shown due consideration for ability and

fitness, and has not listened to the politicians.

When Dr. Joseph Robbins, of Quincy, resigned the superintendency of the Central Hospital for the Insane, at Jacksonville, there was immediately a large number of names proposed for his successor. The Governor and Trustees, instead of depending on applications and endorsements coming through the usual political channels, immediately entered into consultation with the profession, including members of our Judicial Council, to discover if possible the most suitable man for the place.

The Governor in reply to an inquiry on the subject made by the Council, assured them by telegraph that the appointee must be a man who had had experience gained in a hospital for the treatment of the insane. This promise has been fully lived up to and our profession should recognize the position taken by the Governor in this matter.

After considering a number of available men, some of whom were not applicants, the Trustees, in consultation with the Governor, selected Dr. Harry B. Carriel, heretofore acting superintendent of the new institution at Bartonville, Ill. This is simply the promotion of a good man because of his qualifications and is in no sense a political appointment. In fact one can readily see that there were a number of strong political reasons why Dr. Carriel should not have been appointed, but these did not deter the Governor from doing what he thought was for the best interests of the institution.

Dr. Harry B. Carriel, the new superintendent of the Central Hospital, was born in the State Lunatic Asylum, at Trenton, N. J., in 1863. His grandfather, Dr. Henry Butolph, was superintendent of that institution, and his father was first assistant physician. Later Dr. Carriel, Sr., was appointed superintendent of the Central Hos-

pital, at Jacksonville, where he continued with distinguished success for twenty-three years, and his son has spent most of his life there. He attended the Medical Department of the Northwestern University, from which he graduated in 1889. He then went abroad for a year of post-graduate work in Germany and Austria. After returning he practiced medicine in Chicago for a number of years until appointed first assistant physician to the Jacksonville Institution by Governor Tanner. He continued in this position until last December, he was made acting superintendent of the Institution for the Insane at Bartonville, Ill., to fill the vacancy made by the death of Dr. Winslow.

Dr. Carriel was born in an institution for the insane. Both his father and grandfather were superintendents of exceptional abilities, and most of his life has been spent in the institution over which he has been appointed superintendent. He has ample qualifications, and we believe he will be successful. We congratulate the Governor and Board of Trustees on the appointment of Dr. Carriel.

#### ADVANCING THE STANDARD.

A committee of which President G. W. Webster was chairman presented and the State Board of Health adopted a report at its recent quarterly meeting requiring a higher standard for medical colleges. The report of the committee will be printed in our next issue, having reached us too late for this. We have space, however, for the following encouraging editorial comment from the Chicago Tribune.

#### Give Us Better Doctors.

The Illinois State Board of Health wishes the people of Illinois to have better doctors. That is a kindly wish and the board is doing what lies in its power to secure them. It has raised the standard of qualifications for the practice of medicine in the state. It demands a longer course of study in medical colleges and familiarity with high school studies from applicants for admission to such colleges. Protests against the action of the board will be

heard in some quarters. Men who will be prevented by it from practicing in Illinois will complain loudly. The general public which wishes for the best medical service approves of that action.

It was a difficult matter to get through the general assembly the first act to regulate the practice of medicine in this state. There were many in and out of the legislature who had an idea that medical knowledge came by nature rather than by education and that the medical schools gave their graduates little beside diplomas. The "new fangled notions" about denying to men without diplomas the right to physic people whom they could induce to go to them were not popular at the outset. Today the case is different. It is true quacks still thrive and patent medicines find a ready sale, but there is a keen popular appreciation of the superiority of the trained to the untrained or poorly trained doctor. It is indeed partly because of outside pressure that medical colleges are lengthening the term of study and insisting on graduates going out into the world with a much larger stock of learning than of old.

This comes hard sometimes upon "the poor young man" who has money enough to take a short but not a long course in law or medicine, but there are occasions where the welfare of the community must not be sacrificed to promote the welfare of the "poor young man." The stricter requirements of this day keep out of the professions a few who would have adorned them if fortune had been kinder. They keep out a much larger number of unfit men at whose hands patients and clients would have suffered.

#### Resolutions Adopted by the Illinois State Board of Health May 5, 1902.

Whereas, A. C. Corr an ex-member and ex-president of the Illinois State Board of Health, recently died in his home in Carlinville, Illinois; be it

Resolved, That we, the members of the Illinois State Board of Health, in regular session, take pleasure in recognizing the fidelity and industry with which Dr. Corr discharged his duties while associated with this Board.

Resolved further, That we extend to the wife and family of the late Dr. Corr, our sympathies in the great loss they have sustained and that a copy of these resolutions be furnished to them and to the Illinois State Medical Journal for publication.

#### Local Societies.

The Chicago Medical Society at its recent annual meeting elected the following officers:

W. A. Evans, president; Jacob Frank, 1st vice president; R. B. Preble, 2d vice president; Frank X. Walls, secretary; A. E. Halsted, treasurer; D. J. Doherty, necrologist.

F. X. Walls,  
Official Reporter.

The Stephenson County Society of Physicians and Surgeons held its annual meeting at the court house, July 10, 1902. The following officers were elected:

President, J. F. Fair; vice-president, J. H. Stealey; secretary and treasurer, R. J. Burns. Censors, J. W. Rideout, W. E. Clay and T. J. Holke.

S. L. Oren, of Davis, and E. H. Cook and E. A. Reed, of Winslow, were admitted to membership, and the names of Drs. Buswell and Karl Snyder were proposed.

A committee composed of the president and the following physicians was appointed to prepare a program for the next meeting of the society three months hence: C. R. Sheetz, J. H. Stealey, W. B. Stiver, W. E. Clay and R. J. Burns.

A committee of three was appointed to arrange the county fee bill to cover service not included in bill.

R. J. Burns,  
Official Reporter.

The Fulton County Medical Society met in Dr. Strode's office in Lewiston, July 1st, 1902.

Called to order by President Stoops at 12 noon.

The following members were present: Heise, Plummer, Stoops, Connelly, Nelson, Ray, Strode and Sutton.

The president appointed the following committee on the annual meeting: Zeigler, Sutton and Scholes.

Dr. Connelly presented a paper on **Summer Diarrhoea of Children**.

Dr. Strode gave a short talk on hygiene of children during the heated term.

Dr. Blackstone was not present.

Dues collected, E. S. Nelson, \$1.00.

D. S. Ray,  
Official Reporter.

The Randolph County Medical Society met May 6th, 1902, at "Bleem's Hall," at 11 o'clock A. M., to perfect organization, W. R. McKenzie in the chair. The society has enrolled most of the physicians of the county and is in a flourishing condition, several new members adding their names at this meeting. The officers of the society are: W. R. McKenzie, president; A. T. Telford, vice president; H. A. Dinges, P. G. Gillen, and A. D. Steele, board of censors, and H. C. Adderly, secretary. Several very interesting papers were read, and discussed by members of the society. President appointed Drs. H. A. Dinges, C. G. Smith and N. B. Panther as committee on program for next meeting. Society adjourned in due form to meet at Red Bud the 2d Tuesday in October.

H. C. Adderly,  
Official Reporter.

The Southwestern Medical Society of Chicago held its 21st regular meeting at 540 West 63d street, Tuesday, June 10th.

President Miller called the meeting to order at 9:30. T. C. McGonagle then presented a

case of **Cretinism** which has been under treatment for two years and nine months, exclusively by thyroid extract. There is a very marked improvement shown in every particular.

Dr. Rose then showed a case of **Aortic Incompetency** with all the typical findings marked.

Dr. Butt showed a case of **Chlorosis** which he had cured by means of Tinct. Ferric Chlor. and Liq. Potass. Arsen.

There was the usual discussion followed and then we proceeded to lunch, after which Dr. Miller presented his report as delegate to the State Medical meeting at Quincy.

The question of affiliation with the Chicago Medical or Cook County Society was then liberally discussed and a committee of Green, Wier and Lovewell, Jr., was then appointed to confer with the Cook County Society to learn the requirements, etc., etc., of affiliation, and to report at the July meeting.

Thos. C. McGonagle,  
Official Reporter.

The Bond County Medical Society was called to order on July 3d at 10 A. M. by President E. P. Poindexter. Members present: J. A. Wanen, E. P. Poindexter, W. T. Easley, J. H. Gordon, D. R. Wilkins, B. F. Coop, H. C. Early, E. A. Glasgow and A. B. Cary.

Paper on **typhoid fever** and treatment was read by E. A. Glasgow, and discussed by all present.

Clinic by Drs. Smith and Coop was discussed.

S. A. Vaughn of Smithboro made application and was elected to same. Committee of Drs. Easley, Wanen and Coop was appointed by the chair to draft resolutions of respect on the death of J. A. Black of Pleasant Mound, who died June 1st. The next meeting will be September 4th, when autumn diseases will be discussed.

W. T. Easley,  
Official Reporter.

The Greene County Medical Society was organized on Friday, June 27, 1902, at the city council room in White Hall.

The following physicians were present: F. P. Norbury, Jacksonville; F. A. Clement and H. Converse, Greenfield; J. A. Cravens, Wrights; E. A. Higbee, Roodhouse; H. W. Chapman, A. W. Foreman, H. W. Hand, J. W. Redwine, A. Bowman, G. W. Burns, H. A. Chapin, White Hall.

Dr. Norbury, representing the State Medical Society, was temporary chairman, and Dr. Chapin temporary secretary.

Drs. Chapman, Clement and Chapin were appointed a committee to prepare a constitution and set of by-laws.

The following officers were elected: F. A. Clement, president; H. W. Hand, first vice president; J. A. Cravens, second vice president; H. A. Chapin, secretary and treasurer;



censors, H. W. Chapman, H. Converse and E. H. Higbee.

After transacting other business relative to organization, the society adjourned to meet in Carrollton on Friday, July 18.

**The Jacksonville Physicians' Club** met July 3d at the office of Carl E. Black. Dr. Black illustrated by means of his own system of office records the subject of Card Indexing and Cataloguing, or in brief, "**The Card System.**" Having adopted this system some years ago, the speaker was very enthusiastic in its recommendation. He uses the card system for indexing his library, his current literature, his letter file and all monographs, reprints, etc. He exhibited his case cards and explained his system of classifying cases and keeping accounts. The leader held that there is no department of what is ordinarily known as "bookkeeping" that cannot be more economically and satisfactorily conducted by means of cards. He showed that many of the largest business concerns in the country have adopted this system, and held that all seeming obstacles vanished on a closer acquaintance with the system. It is destined, he thinks, to be the system of "bookkeeping" of the future, as it is already the system of library cataloguing.

For case records, the leader always keeps a few of the standard cards in his pocket-book, and on his desk. The name, age, symptoms, history, etc., of each patient is entered on a card and the card placed in position indexed by the guide card with the name of the patient, this same guide card serving as ledger, all financial entries being made in brief upon it. He also enters the same case if an important one under the name of the disease or operation for which it calls, thus classifying both patients and cases. He called especial attention to the fact that any one department of record keeping could be used as a beginning, and the system would grow according to one's tastes and needs. It is a mistake to adopt the system full-grown.

Several members of the Club had adopted the system in a more or less modified form.

A. L. Adams has used the system in all his business and professional dealings for some years and endorsed it most enthusiastically. He emphasized the importance of small beginnings. "Any man who cannot get enthusiastic over the system with a thousand cards and a paste-board box, need not spend money on a costly cabinet outfit."

Club adjourned until the first Saturday in October.

David W. Reid,  
Official Reporter.

**The Jersey County Medical Society** held its regular monthly meeting July 9. The subjects under discussion were cases illustrative of **gangrene** and **spina bifida**. The case of gangrene was in a boy of 10 and followed diphtheria. Occlusion of circulation took place just

below the knee in both legs. Circulation was restored in one limb. In the other gangrene advanced practically to spontaneous amputation. Patient recovered. The case of spina bifida was a pronounced one. The middle lumbar region was the site of the tumor. The opening was very large. Child's limbs were both twisted and useless. There was no cystic or rectal disturbance. Death from inanition occurred at six months.

After discussion of the subject of concussion of the spine, the society adjourned.

H. R. Gledhill,  
Official Reporter.

**The Decatur Medical Society** met in the rooms of the Decatur Club, Tuesday evening, June 26. In the absence of both the president and vice-president, N. D. Myers was elected chairman.

The minutes of the previous meeting were read and approved. C. Martin Wood, the retiring treasurer, read his report, and it was accepted by the society.

The secretary read a communication from Carl E. Black, chairman of the Legislative Committee of the Illinois State Medical Society, relative to the proposed bill establishing a **State Board of Medical Examiners** and providing for better regulation of those who treat the sick. After a short discussion action on the matter was deferred until the next regular meeting, so that the members might be better informed upon the exact nature of the proposed changes.

W. A. Dixon then presented an interesting paper entitled "**Notes from Chicago,**" in which the writer gave a resume of a six weeks' clinical course in the hospitals of Chicago. After a short discussion the society adjourned.

The Program Committee has prepared programs for the coming six months and has not only appointed the writer for each meeting, but has assigned the subject for each paper, in the hope that by this means we may secure papers of more general interest to the society.

Lynn M. Barnes,  
Official Reporter.

#### **Alexander County Medical Society.**

Meets Second Tuesdays of January, April, July and October.

#### **Officers.**

President, S. B. Carey.....Cairo  
Vice-President, J. W. Dunn.....Cairo  
Secretary and Treasurer, J. T. Walsh....Cairo

#### **Members.**

†\*Bondurant, A. A., Cairo.  
\*Carey, S. B., Cairo.  
†Dunn, J. W., Cairo.  
Fields, W. H., Cairo.  
†\*Grinstead, W. F., Cairo.  
†McManus, J. M., Cairo.  
McNemer, Geo. H., Cairo.  
Oakley, J. H., Cairo.  
†\*Sullivan, J. G., Cairo.  
Walsh, J. T., Cairo.

**Edwards County Medical Society.**

Meets in April, July, October and January.

**Officers.**

President, W. E. Buxton.....Samsville  
Vice-President, J. S. Williams.....Albion  
Secretary and Treasurer, J. H. Lacy....Albion

**Members.**

†Buxton, W. E., Samsville.

Harwood, S. E., Ellery.

Lacy, J. H., Albion.

Low, A. C., Albion.

Mass, H. C., Albion.

McCormack, J. L., Bone Gap.

Williams, J. S., Albion.

**Massac and Pope Counties.**

The physicians of the above named counties held a joint meeting, at Lewis' Springs, one mile south of Rose Bud, June 26.

A sumptuous dinner was spread from the well filled baskets, furnished by the various members.

J. W. Dixon, president of Pope County Society, was made chairman for the day, and A. C. Ragsdale secretary. The chairman, in a few and well chosen words, thanked the members for the honor of presiding and made a very pretty speech in favor of organization. C. E. Trovillion responded and spoke of the recent organization in Pope county, and predicted that the time was near when every county in southern Illinois would have a medical society.

G. A. Stewart reported a surgical case, an **abscess of the liver** which had been operated upon by opening twice, the case now progressing favorably. This case was discussed by all the members present and was quite interesting. Dr. Stewart next exhibited a **piece of skull bone which had been removed from the frontal region** of a young man who had been struck just over the eye and inflicting quite a large wound in the soft parts as well as driving a portion of the bone into the anterior hemisphere of the brain. The case was remarkable, as the patient had lost about two teaspoonfuls of brain substance which was discharged through the opening. Patient never had any fever, never missed eating a meal, was up walking around in about 8 days, with mind and memory good, could not discover any effect whatever from the loss of brain substance.

This case was now discussed, after which the former case, that of the liver abscess was again taken up, and Dr. Orr advocated keeping the wound open and dressing with iodoform gauze. Dr. Ragsdale advised packing deep but lightly, to facilitate drainage, after thoroughly irrigating with hot carbolized water, to prevent sepsis by absorption.

Dr. Fisher spoke of the sub-normal temperature, and attributed it to a loss of liver tissue and venous stasis, and gave an unfavorable prognosis.

Dr. Helm read a paper on "The Report of Two Cases." The first, a clinical history of a case of **typhoid fever**. E. C. an interne of the Anna Asylum. He noted a typical case,

with epistaxis, tender and doughy abdomen, lumbar pains, diarrhoea, insomnia, meteorism, iliac tenderness, anorexia, etc. Hemorrhage from the bowels, followed by marked prostration. These symptoms were followed by an embolism of the femoral artery, resulting in gangrene of the leg without any line of demarcation. No amputation was performed and the patient grew worse until about the 22d day, when a perforation of the bowel occurred and the patient died.

Here the essayist stopped to hear the discussion of this case before reading the remaining report. Dr. Trovillion said, an amputation would have done no good, as the patient would have died from the perforation. Dr. Helm asked the cause of the embolism and various theories were advanced, after which Dr. Helm read the remaining portion of his paper, which consisted of the enumeration of a set of symptoms simulating remittent fever, which turned out to be a case of **smallpox**. He withheld his diagnosis and the members guessed bilious fever, intermittent fever and remittent fever and then Dr. Helm stated that he found out what the diagnosis was in passing the patient's house next day, by seeing a yellow flag on the gate. This demonstrated the fact that we should sometimes be slow about forming an opinion, as it is easy to be mistaken.

On motion, we adjourned for dinner, which proved to be an elaborate affair, and many were the "gripes" and "cramps" that followed that repast. The president called the meeting to order after dinner, and Dr. Trovillion read a paper on **Dysmenorrhoea**. He first gave definition and then clinical history, and the differential diagnosis, and said the disease was often complicated with ovaritis. He attributed the immediate cause to trouble within the uterus; and gave the various theories of cause, but said the most frequent was obstruction to the menstrual flow. He only used medicines as palliatives, and has never got any curative effect from medicinal means. He recommended dilatation of the os, frequently repeated, and the application of carbolized glycerine for the hyperaesthesia.

There being a clinic in waiting the discussion of this paper was postponed to examine the same. A young lady, who had been accidentally shot in the right side of the neck with a 22-caliber pistol, ball entering just in front of the sterno-cleido-mastoid muscle, about one inch below the ear. The ball was never located. It had ranged upward and was thought to be lodged somewhere at the base of the skull about the body of the sphenoid bone. The wound had healed very quickly and caused the girl no trouble whatever, except it had produced strabismus convergens almost immediately. The ball had either cut, or was producing a pressure on some nerve trunk which had caused paralysis of the external rectus muscles.

In the discussion it was recommended that the location of the ball was such as to preclude any attempt at removal, but the young



lady was advised to wait a while and note change that would take place in the strabismus, and if then necessary, to undergo an operation for correction of the trouble, and to then have a pair of glasses adjusted which would give her good sight, provided the ball gave her no further trouble.

After this Dr. Trovillion's paper was discussed by several of the members. Dr. Fisher thinks the cause of dysmenorrhoea is not altogether local, but systemic usually, and he advocates from 6 to 12 months treatment along a reconstructive line.

Dr. Fisher read his paper on "This Outing," in which he cited many instances in which we fire at "knot holes" and miss the mark by a wrong diagnosis. His paper was excellent and full of humorous witticisms.

Dr. Ragsdale next read a paper on *ophthalmia neonatorum*. The first page of which was devoted to humorous greetings for the occasion, and after giving a pretty thorough consideration to causes, diagnosis, varieties and treatment, he then devoted considerable space to the importance of prophylaxis, urged all general practitioners and mid-wives to use great care in cleansing infants eyes, and stated that the majority of cases could be prevented if properly handled. He said all new-born baby's eyes should be thoroughly cleaned with pure water, or a weak bichloride solution, and if specific disease in the mother was suspected, the greatest care should be exercised to prevent any discharge remaining on the lids, or in the eyes, to infect them.

This paper was discussed freely by several members and proved to be very beneficial to all by exciting thought along that line.

The president, J. W. Dixon, read a paper on *cholera infantum*. He enumerated the causes, as bad hygiene, infectious organisms, ptomaines, and bad feeding. Treatment, anti-toxic; empty the bowels, inject normal salt solution, cooling baths, bismuth, carbolic acid, etc. Peptenzyme every three or four hours, he highly praised. Cold water internally, externally and eternally.

The paper was highly commended, especially the part relating to the water treatment.

After this discussion, there was an adjournment for supper and when all bodily wants had been satisfied, order was called again and on motion it was agreed to meet at the Springs again next June.

In the midst of congratulations and general enthusiasm, all departed for their respective homes.

A. C. Ragsdale,  
Official Reporter.

The Fox River Valley Medical Association held its seventy-fourth semi-annual meeting in the Spurling Block at Elgin, Illinois, on Tuesday, May 13, 1902, with Geo. F. Allen, president of the society, in the chair, the following members being present:

E. V. Anderson, C. W. Hawley, Jas. Campbell, C. A. Buswell, T. E. Macauley, A. B.

Sturm, J. A. Rutledge, W. J. Calhoun, C. D. Calhoun, J. F. Bell, E. H. Abbott, H. L. Pratt, F. H. Jenks, R. M. Curtiss, D. E. Burlingame, C. L. Smith, J. E. Bumstead, H. J. Achard, W. S. Brown, H. G. G. Schmidt, S. P. Brown, T. N. Austin, G. J. Schneider, Mary C. Knight, M. E. Fullam, A. A. Fitts, C. B. Slater, W. A. Nason, H. W. Richardson, H. F. W. Bartells, J. G. Taper, H. J. Gahagan.

Applications for membership were made by O. L. Pelton, H. D. Hull, C. M. Johnson, Geo. A. Jett and C. W. Gould, and upon motion they were elected.

The special business of the meeting was the adoption of the new constitution. The clause which brought about the most discussion was that of membership, it being finally decided to admit to the society any physician who had a certificate from the State Board of Health. Those graduating from other than the regular school of medicine to sign the following additional form:

"In consideration of my application for active membership in the Fox River Valley Medical Association made....., 190.., and in view of the fact that I have graduated from a .....School of Medicine, I hereby agree that in the future I shall not profess to practice according to this or any other dogma."

The following papers were read:

G. J. Schneider, Elgin, "Injuries of the Eye-ball." (See below.)

C. A. Buswell, Freeport, "X-Ray Therapeutics."

C. L. Smith, Aurora, "Surgical Appendicitis."

The papers were very interesting and were generally discussed. At the conclusion of the Scientific Session the members, their wives, and invited guests, to the number of fifty-seven sat down to a feast prepared by the Women's Relief Corps.

The Post Prandial was in part as follows:

D. E. Burlingame, M. D., Toast Master.

"The Paradoxical Position of the Physician," H. J. Achard, M. D.

"The Doctor and the Lawyer," F. W. Joslyn.

"Medical Fallacies," Geo. F. Allen, M. D.

"The Physician and the Priest," Rev. J. J. McCann.

The next meeting of the association will take place at Aurora the second Tuesday in November.

H. J. Gahagan,  
Official Reporter.

## INJURIES OF THE EYE-BALL.

By G. J. Schneider, M. D.

Attending Oculist and Aurist St. Joseph's Hospital and Sherman Hospital, Elgin, Ill.

Injuries of the eye-ball are divided into four classes: 1. Injuries from contusion. 2. Injuries from penetration. 3. Injuries from penetration with retention of the body. 4. Injuries from light, heat and chemical substances.

The subject of injuries is a large one, and



it would be impossible to cover the entire ground in a short paper such as I have prepared, so, if you will bear with me, we will consider briefly injuries of the eye-ball from penetration, with and without the retention of a foreign body.

The most frequent causes are blows received from sticks, toys, air-guns and scissors in the hands of children while at play; the explosion of gun-powder used extensively before and after the Fourth of July; and wounds from small pieces of metal such as iron, copper, stone and glass, the results of accidents that are very frequent in cities among the industrial population. These small particles usually strike with a high projectile force, and seldom fail to puncture, and the wounds are of importance because of the frequency with which they are complicated by penetration of the globe and by septic infection. The most important symptoms of perforation are diminution of interocular tension, shallow and obliterated anterior chamber, and in large wounds, a prolapse of the subjacent structure, depending much upon the location of the wound. The prolapse may include parts of the iris, ciliary body, vitreous or the crystalline lens. In some cases even the entire contents of the globe may escape, in which case there is no hope for the retention of the ball, and enucleation presents itself for immediate performance.

The main point to decide is whether a foreign body remains in the eye. If so, the case runs a much more serious course. If you can possibly exclude a retained body, the fate of the eye depends upon whether the wound heals with or without inflammation. Healing without inflammation is to be expected in the majority of clean non-infected cases.

The cornea is the most liable of the eye structures to receive an injury on account of its extended position, and its penetration is followed by the escape of a portion of the aqueous humor, and a protrusion of the iris, especially if situated in or near the sclero corneal junction. The prolapse is due partly to the iris losing the support of the aqueous which has been evacuated, and partly to the pressure of the remaining fluid which also tries to escape. The pupil is dragged towards the prolapsed portion of the iris, and if this remains un-reduced, the iris unites to the lips of the wound and a permanent deformity of the pupil occurs. In many of these cases the lens is injured and a cataract is the result, manifesting itself sooner or later.

The first thing to be done with such a condition is to thoroughly anesthetize the eye with cocaine, using a solution of four per cent (4 per cent), render the parts antiseptic using a bichloride solution 1 to 5000 followed with a saturated solution of boracic acid, trying to replace the protruding part, if possible. We may for a few minutes massage the eye by rubbing the closed lids gently in a circular movement over the surface of the eye-ball. If this does not succeed in replacing the

prolapse, use a probe or a spatula, and, should all attempts at reduction fail, the protrusion must be cut off, performing the same operation as for an ordinary iridectomy. If the protrusion is left to itself, it is liable to prove a source of irritation, gradually increasing in size, drawing out more of the iris, and producing a larger cicatrix, and a more distorted pupil than when the iris has been cut off.

In some cases the wound is more extensive, involving the cornea and sclera, sometimes laying open the entire eye. If the eye has not been eviscerated, all of the prolapsing structure should be cut off, and the wound carefully cleansed and closed with one or more sutures. There is no objection to placing the suture in the sclera tissue, but I prefer in the majority of cases to draw the conjunctiva over the wound, suturing it in place of the sclera.

Cold in the form of a compress and pressure bandages should be applied for the first few days, together with the repeated use of a mydriatic.

When the eye is generally disorganized, iridocyclitis commencing, and the eye sightless, I would advise enucleation, as it will shorten the period of disability and remove the danger of sympathetic ophthalmia.

Injuries of the eye due to penetration and retention of a foreign body come under a distinct class. The patient usually tells us that he has been working with heavy tools, such as hammer and chisel, and that upon striking a blow, he felt something hit him in the eye. The small particle, if the tools are examined, will have come from the hammer, especially if it be an old one. The patient may try to assure us that nothing has entered the eye—"simply was hit, and the flying body glanced off." Always ignore this statement and make a thorough examination. The patient will probably complain of only slight pain, some photophobia and lachrymation with diminution of vision. On inspection, we may find only a small scar in the cornea and a slit in the iris, with the edges of the wound in apposition. If the case is seen early after the injury, we may be able to locate the body with the ophthalmoscope and oblique illumination. If the lens has been injured, a slight hemorrhage may have ensued, and this method is of little use.

We next dilate the pupil with atropine so as to enable us to examine the interior of the eye, and a very small particle which might otherwise escape detection, may be brought into plain view.

When nothing can be done with the aid of the ophthalmoscope, the field of vision should be taken, with a candle in a dark room, and search be made for a marked scotoma or other defects of vision which may indicate the location of the body.

If we find sudden and complete blindness, the probabilities are that the optic nerve is injured by the body having entered the disk or by its having penetrated the nerve behind the eye-ball.

Having failed to locate the body by ob-

jective means, and finding the subjective symptoms insufficient to enable us to clear up the diagnosis, the X-ray may solve the problem. Should we get a shadow we have positive proof, but we must remember that some certain foreign bodies do not cast a shadow, and others are too minute to do so.

Dr. Campbell succeeded in locating a BB shot for me in a case to which I was called in consultation. The case was that of a child about twelve years of age. The accident resulted from using an air-gun, the shot entering the eye through the cornea, and injuring the lens and iris. The tension was reduced and the anterior chamber filled with blood. I gave an opinion that the bullet was in the eye, and the fluoroscope confirmed the diagnosis. I advised that an attempt be made to remove the shot, but did not succeed in gaining the consent of the parents, and up to six months past, the eye was quiet, and seemed to tolerate the presence of the bullet.

If the foreign body is of steel or iron, the magnets are our chief reliance. There are two instruments—one the small magnet, intended to enter the eye, either through the wound or through a new opening made for the purpose. The foreign body will cling to the instrument as soon as it comes in contact with the steel, and can thus be easily removed when the instrument is withdrawn. The other is a large stationary instrument called the Haab magnet, designed to draw the fragment of steel into the anterior chamber or into view, the extraction being completed by the use of the small instrument. This large magnet is also useful as a diagnosis instrument. In injuries with the retention of steel or iron, the eye is brought up to the magnet, and, if the fragment is lying loose in the vitreous, or is not too firmly imbedded, the patient will experience pain when the body is moved. In favorable cases it may be drawn into the anterior chamber at once.

In dealing with foreign bodies we are sometimes baffled to know just what to do in certain cases. After all the diagnostic means we have at hand are exhausted, we may still be in doubt as to whether we are dealing with a simple wound or one with the retention of a body. If the latter, I advise the removal at the earliest possible moment. If the body is of steel or iron, the magnets are our best instruments to employ. Should these fail to meet the requirements of the case, we have to resort to the use of forceps or spoons, and it is allowable to open the eye for this purpose. If we are unable to remove the body by the above means, we must decide whether to enucleate the eye at once, or allow it to remain and inform the patient of the peril he is in, not only of losing the injured eye, but its fellow as well, from sympathetic ophthalmia. The successful removal of the body does not insure the safety of the eye; the sight is usually lost, and sooner or later the ball will have to be enucleated. The best results are recorded of those case where the body was removed early.

The Chicago Neurological and Society and Chicago Medical Society held a joint meeting April 2, 1902 with the president, Daniel R. Brower, in the chair.

#### Definition and Pathology of Neuritis.

Archibald Church spoke on this phase of the subject. He said that some fifteen years ago nothing was heard of neuritis. There was even a general feeling that the nerves were to some extent immune against the processes of inflammation. Ten years ago a definition of the term neuritis would have been of the greatest ease; if one had said that it meant inflammation of the nerve, he would have covered the ground. This condition, at first apparently simple, had been found to be complex, and now the term neuritis was a generic one. It had to some extent been stretched out of its proper significance.

He divided cases of neuritis into the true form, marked by inflammation in the nerve or its fibrous support, and those forms of neuritis characterized by degenerative processes. True neuritis, the first variety, was generally confined to a single or to several nerves, but it did not, as a rule, involve a great number of nerves. It was inflammatory, and usually arose from the surrounding tissues involving the nerve by extension, by continuity or contiguity.

It may be secondary to a new growth. Any variety of neoplasm in the neighborhood of the nerve may by infiltration set up irritation and terminate in actual inflammation of the nerve. In some instances the nerve was invaded by the tubercle bacillus; in others by the germ of leprosy. Syphilis involved the nerves much more frequently than was supposed. Sometimes, when sciatica does not yield to ordinary methods of treatment, a course of mercury is in order. In leucocythemia and a number of other disorders of the blood characterized by dyscrasia, and disintegration of blood elements, portions of the peripheral nerve were inflamed, presenting a true neuritis.

Attention was directed to the degenerative form of neuritis at considerable length. The speaker said it was more common than the inflammatory variety. The degenerative forms of neuritis were generally the result of toxic causes or elements, the principal one of which were lead and alcohol. Various cachexiae, especially syphilis, were attended by manifestations of degeneration in the motor portions of the peripheral apparatus.

The character of the degeneration in multiple neuritis was practically a Mullerian degeneration. Multiple neuritis must be looked upon as the result of systemic poisoning, and as a systemic disorder involving all portions of the nervous apparatus. The chief toxic substances which give rise to multiple neuritis were alcohol, lead, arsenic. Reference was made to the occurrence of the epidemic in Manchester, England, in connection with beer-drinking.

Owing to the idiosyncrasy of a patient, mer-



cury given in the usual manner had been known to set up all the symptoms of multiple neuritis, the neuritis subsiding upon the withdrawal of the mercury. Other agents were mentioned as toxic substances capable of setting up multiple neuritis, among them phosphorus, sulphur, etc.

Among the autotoxic causes of multiple neuritis, he spoke of diabetes. In chronic interstitial nephritis, owing to a toxic condition, there was disturbance of the nervous apparatus, showing itself in vague, yet when carefully considered, highly suggestive sensory manifestations of disturbance of the nervous apparatus. Another group of autotoxic factors arose from intestinal conditions. Individuals subject to dysenteries, parasites and chronic intestinal disorders, might develop multiple neuritis. All of the infections practically were capable of inducing multiple neuritis through their toxic action.

In pernicious anemia one might have all the symptoms of neuritis which were attended in the majority of cases by histological changes in the spinal cord.

In old age, in patients in whom there was extreme arteriosclerosis, there were often manifestations of multiple neuritis, the disease arising from a number of causes. For instance, the artery which supplied the nerve, owing to an atheromatous condition and a sclerotic state, did not deliver enough nutrient material to the nerve, so that nutrition was disturbed locally.

Sydney Kuh discussed the **Symptomatology, Diagnosis and Differential Diagnosis of Neuritis**. He called attention to the fact that in toxic neuritis, and possibly in other forms, changes are found not only in the peripheral nerves, but in the cells of the central nervous system as well, and that a large number of the nerve fibers may be found degenerated in cases in which *intra vitam* no signs of disease in them could be detected. The disturbances of sensibility, both subjective and objective, were first described, then those of the higher senses, those of motility, of electric irritability, of co-ordination, of reflexes, of trophic, secretory and vaso-motor functions, etc. Korsakow's psychosis as a symptom of multiple neuritis was discussed in detail, and the constitutional symptoms accompanying neuritis briefly mentioned.

In speaking of the diagnosis of neuritis, rules were given for its differentiation from rheumatism, disease of bones and the periosteum, hysteria, neuralgia, cerebral disease, especially that involving the facial and oculomotor nerves, acute and chronic poliomyelitis, locomotor ataxy, muscular dystrophy and polymyositis.

Elbert Wing read a paper on **Treatment of Neuritis, Other Than Surgical**. In the treatment of neuritis it is of first importance to make a correct diagnosis; to determine that the case is one of neuritis, and whether simple, multiple, toxic, acute or chronic. The objects of treatment are removal of the cause, and restoration to normal conditions. When

due to pressure, instrument 1 or from foreign growths, removal of the cause is often a simple matter, but may be difficult. A similar statement applies to cases due to, and complicated by, gouty or rheumatic states. In these cases disappointment is not apt to follow correct diagnosis and efficient methods of treatment. In cases due to mineral poisons the detection of the source of the offending element may at times be difficult, and in alcoholic cases clever deception on the part of the patient may increase the difficulty. In cases which are really those of neuritic parenchyma—true degeneration, the pathologic conditions of course continue long after the specific cause is removed.

Relief of pain is imperative in all acute cases of severity. For this purpose hot cloths properly applied—an efficient method was described—along the course of the nerve often are of great effectiveness. Counter irritation may answer, but should never be applied in the area of distribution of the affected nerves. In chronic cases the actual cautery is the best counter irritant. In acute simple cases Gower's liniment is of great value. Sand bags, slings and splints have a useful function. They may promote relief of pain through limitation of motion and prevent and correct deformities. In most severe primary cases morphine is needed for the relief of pain. The coal-tar preparations rarely suffice. If used, the doses must be large, frequently repeated, and acetanilid should never be used for this purpose. Morphine, cocaine and other analgesics are most effective when placed, by means of a hypodermic syringe, in the immediate proximity of the affected nerve. Stretching of the nerve, in simple sciatic cases, by forcible flexion of the trunk upon the extended lower extremities, or of the extended extremity upon the trunk, the body supine, is at times remarkably successful both in relieving pain and promoting recovery. The same is true of efficient massage. The use of electrostatic currents and the Roentgen ray have a useful future in the relief of pain in probably all cases of neuritis. Unfortunately they are not often available for treatment of these cases. In some cases the galvanic current has decided pain relieving power, in others its use increases pain. A safe rule is never to use a current strength which causes a decided increase of pain at the time of its use, or any persistent increase.

The rare forms of neuritis due to syphilis are treated along the general lines of the two diseases and need no elaboration in this connection.

The various forms of multiple neuritis differ radically in their causes, but are so essentially similar in their pathologic conditions in many respects that their treatment is much along the same lines. These lines are removal of cause, prevention of contractures, protection of tender extremities, at times relief of pain, and finally the general tonic treatment of any severe chronic disease in which the essential lesions are degenerative. In this list general tonics



take high rank and the salts of strychnia the first. As in any other chronic condition, the form of tonic used must be occasionally varied. In the chronic forms of simple neuritis the use of one grain of blue pill, two or three times daily, and for long periods, produces favorable results, not simply chronological. In polyneuritic cases, massage, skillfully used, the proper use of splints and electricity, together with voluntary exercise of muscles, bring about cures even in the worst cases.

Two classes of multiple neuritis require special mention. As a rule, in alcoholic neuritis, alcohol may be withdrawn at once. In the variety of neuritis due to lead, the conventional attempts at specific removal of the mineral are at first demanded.

The causes of death in the fatal cases indicate clearly the special care which is needed, cardiac and pulmonary weakness being induced both directly by the special cause in each case and by the autointoxication which may arise in any case. These principles of treatment must be constantly in mind in every case of multiple neuritis. They are usually simple and well understood, but must be the objects of constant watchfulness.

**Surgical Treatment of Neuritis.** Weller Van Hook discussed this phase of the subject, saying that surgery is in a position to be of service in the treatment of the consequences of neuritis rather than in the management of the actual disease itself, whether acute or chronic. In the acute form of the disease, aside from those instances in which a suppurative lesion is present, very little can be done by surgical means for the relief of the patient excepting to afford some aid by rest. Where pressure upon a nerve is superinducing neuritis, or neuralgia, the case belongs within the province of surgery. Where fractures primarily or secondary involve large nerve trunks, operative procedures are frequently needed; for example, where a fractured clavicle presses upon the brachial plexus, relief by elevating the fragments and separating the connective tissue from the nerve is of absolute necessity. Not infrequently the long bones, when fractured, similarly press upon important nerve trunks.

In open injuries, where infection is likely to occur, the utmost care must be taken by the surgeon to prevent infection of the wound, particularly where large nerve trunks are likely to be involved. There may not be only inflammation of connective tissue around the nerve involving the nerve trunk in adhesions, but it is also possible to have from such a wound a migrating neuritis successively involving different nerves. This form of neuritis is supported as a nosological entity by Krehl, who maintains that well-marked cases of the disease have frequently come under his observation.

In the chronic forms of neuritis surgery is of more frequent avail. It is in the treatment of the consequences of peripheral neuritis that surgery finds the greatest scope. In compression of nerve trunks by periostitis, it is ad-

missible to remove the connective tissue around the nerve, as has been frequently done, an operation which is termed neurolysis.

Tumors of a non-malignant character that press upon large nerve trunks, producing more or less of an inflammatory condition, should be attacked by excision, while those which are of malignant character demand removal of the nerve or of a part of the nerve itself.

The method which one should pursue in the treatment of hemorrhages within and about nerve trunks is yet open to difference of opinion. No definite rules have been laid down for the management of cases of this kind.

In the case of chronic inflammation producing neuralgia in the narrow sense of the word, a variety of surgical procedures are at the disposal of the surgeon. The stretching of chronically inflamed nerves is no longer practiced so freely as was formerly the case; nevertheless, in cases of true neuralgia of the sciatic nerve, Hoffa recommends in selected cases the stretching of the nerve, at first by the subcutaneous method, and later, if necessary, by an open procedure.

The method of extraction of the nerve, exaeresis, at first practiced by Thiersch, is still in very common use. Undoubtedly, the majority of cases of neuralgia of the trigeminus can be cured by exaeresis, and it is by no means necessary that the Gasserian ganglion should be excised in ordinary cases of this disease. On the contrary, this formidable and dangerous operation should be reserved for those cases in which peripheral operations have been thoroughly tried.

When paralysis is a consequence of neuritis, surgery offers relief in many cases by transplantation of nerves or of tendons. Results obtained by this modern method of treatment are very gratifying.

The French school of surgeons, at the head of which is Chipault, have of late shown much enthusiasm in the management of many cases of peripheral nerve disease, particularly of the trophic varieties, by stretching. It is claimed by Chipault that *mal perforant* of the foot can be favorably influenced, in many instances, by the stretching of the nerves of the leg. It is particularly in cases where the sciatic has been injured, or where it has been involved in inflammation of the thigh, that nerve stretching has seemed to be of service in *mal perforant*.

L. Harrison Mettler referred to **Sciatica**. Sciatica in some recent text-books was still classified under several heads, as for instance, primary and secondary. The primary are divided into the idiopathic and the special forms of neuritis. He thought this was a mistake. He could not conceive of a secondary sciatica in the sense of a mere pain of the nerve caused by some extraneural pressure. If there is disease of the bone, tumor, or other condition causing secondary disease, either of an inflammatory or degenerative type, in the sciatic nerve, it might seem to be a secondary sciatica, but it is only secondary etiologically. It is really a sciatic neuritis; hence he thought so-called secondary neuralgia, or sciatica, as a special class should be dropped from the books. Almost all the cases he had seen of sciatica ex-

hibited more or less the symptoms of sciatic neuritis. The symptoms which usually accompany so-called ordinary idiopathic neuralgia of the sciatic nerve were those that are characteristic of sciatic neuritis. These were mentioned.

As to the treatment in cases of sciatic neuritis, where there was a rheumatic diathesis, he obtained the most favorable results from the use of the salicylates, pushing them until he got a decided physiological effect. He had not seen such favorable results from the use of mercury or antisyphilitic treatment. Sciatica was not usually caused by syphilis.

C. P. Pruyn said that dentists had a good deal to do with **neuralgia of the fifth nerve**. He was a little surprised on being told by a prominent neurologist that neuralgia of the fifth nerve was seldom caused by tooth irritation. Frequently the patients consulted dentists for relief after they had gone through the gamut of the general treatment by physicians, and tooth irritation was found to be the cause. Often there was calcification of the tooth pulp, sometimes complete, at other times simply a calcified nodule, which caused the whole disturbance. The removal of this nodule effected a cure.

Daniel R. Brower detailed the report of a case of **neuritis of the fifth nerve**, and in taking the patient's history he inquired very carefully into his antecedents, particularly as to syphilis. The patient at first denied syphilis. In early life the patient had had two or three attacks of rheumatism. He was quite anemic. He did not know just how to begin treatment of the case, but first treated him on the anemic theory, and tried to build him up by the administration of appropriate hematinics; at the same time using galvanism. Under this treatment the patient grew worse. He was then treated on the rheumatic line, salicylates and iodides being given. The patient did not improve under this treatment, but became worse. Finally, believing that the patient was mistaken as regards syphilis, he gave him the mixed treatment for syphilis, and the pain disappeared as if by magic. Again he asked the patient in regard to syphilis as the probable etiological factor, and he admitted it.

He had had within three months two cases of neuralgia or neuritis of the fifth nerve, both syphilitic. It was rare in his experience for this nerve to be attacked by the syphilitic poison, but these cases coming so close together were interesting as well as instructive.

O. B. Will, of Peoria, believes that in the **acute primary form of neuritis**, where the patient was suffering much from neuralgia, the best treatment was the administration of chloroform or ether. He used this altogether in his own case, and his professional friends had adopted it, with good results. The chloroform should be administered *per orum*, hypodermically, or by frequent inhalations. He thought there was no agent that would do as much in bringing about permanent relief in the class of cases under discussion as this agent. It should not be administered, however, to the point of anesthesia, but the system should be more or less saturated until pain was relieved.

A. W. Baer had used the salicylate in the **rheumatic form of neuritis**, with beneficial results, especially if not pushed to the point of interfering with the functions of the stomach. He had never obtained much benefit or relief in these cases from external application, outside of heat and cold, except from the effects of rubbing oil on the parts affected. If the neuritis was of traumatic origin, the interrupted galvanic current was by all odds the best, and he had obtained some excellent results from it. Sparks from the static current in cases of toxic neuritis had given excellent results.

Julius Grinker thought motor disturbances were often the most prominent symptoms in cases of neuritis. **Diphtheritic paralysis was nothing but a neuritis** following diphtheria infection manifesting itself by motor disturbances principally, the sensory disturbances taking a back ground, or perhaps not being noticed. Faucial paralysis follows diphtheria. He has seen a staggering gait develop in children after diphtheria. This was nothing but a multiple neuritis. It is well to recognize these forms of neuritis, because by so doing a life could occasionally be saved. Physicians hear of sudden deaths of children after diphtheria. A child is said to get well, walks about, but cannot swallow readily; fluids are regurgitated, and the child suddenly dies. Heart failure is said to be the cause of death. He thought possibly many of these cases were due to vagus involvement, the neuritis having developed and progressed rapidly and involved the vagus, killing the child, the nature of the trouble being unnoticed by the physician. Symptoms should be looked for in every case of diphtheria that has apparently recovered. He urged that the reflexes be tested, as the first symptom noted after diphtheria of oncoming neuritis was absence of reflexes. When the reflexes are diminished or absent, one should look out for neuritis. It might develop rapidly and kill the patient.

Not long ago he was called to see a case in private practice. A child commenced to stagger two weeks after diphtheria. The mother noticed that the child's eyes seemed to be in the same position; in directing the child's attention to anything, it would stare in front of it and not move a muscle. He was called and recognized paralysis of almost all the ocular muscles, also paralysis of the lower extremities. He considered it a neuritis following diphtheria. He gave the child strychnia in large doses, and it is well today. He does not believe in giving the usual text-book doses of 1.120 of a grain, but the 1.30 of a grain, three times a day.

G. W. Hall said he has had the privilege in the last few months of seeing at the County Hospital two extreme cases of **peripheral neuritis** involving all the limbs of the body. The first patient, when admitted to the hospital, was unable to move either a hand or foot, and had no sensory disturbances. In the other case both arms and lower limbs were involved completely, with facial paralysis on one side, finally extending to the other side, with complete motor paralysis of all the limbs. There



were no sensory disturbances. It was important to remember in making a diagnosis that sensory disturbances do not necessarily have to be present. He believes that next to alcoholism sensory disturbances were more frequently present in peripheral neuritis than in any other form. He emphasized the great difference as to the presence and absence of sensory disturbances in the different forms of neuritis, saying that in neuritis following lead poisoning the sensory disturbances were very slight as compared with the motor. In neuritis following alcoholism it was very rare that we did not have sensory disturbances present to a greater or less extent. He believes in many cases paralysis comes on almost simultaneously with sensory disturbances.

Liston H. Montgomery would not care to use such large doses of strychnia as mentioned by Dr. Grinker. A formula which he has used with beneficial results is one composed of menthol crystals, dilute phosphoric acid, and a few drops of tincture of aconite with alcohol.

He thought it was an oversight that no one had mentioned rheumatism as a possible etiological factor of single or multiple neuritis.

Diet was a very important feature in the treatment of many cases of neuritis. Recently he had a patient who had suffered from multiple neuritis which had defied every form of treatment for eight years. One of the first questions he asked was whether any of the former physicians had ever prescribed a diet for the patient, and the patient replied that he was allowed to eat anything he desired. The speaker eliminated a number of articles from the diet, and along with the preparation mentioned he gave iodide of potassium in twelve grain doses, three or four times a day, and under this treatment the patient recovered.

Dr. Grinker did not consider the thirtieth of a grain of strychnia, administered to a child of eight or twelve years of age, a large dose. He had used it in such doses in several cases, with excellent results.

I. A. Abt believes that **strychnia is frequently given to children in too large doses.** Not long since he saw a child at a hospital suffering from extreme rigidity and from opisthotonos. The symptoms made him think of tetanus, possibly a meningitis. He looked at the history sheet and found that the child, an infant not more than a year old, was getting nearly the twentieth of a grain of strychnia in twenty-four hours, and was suffering from strychnine poisoning. During the infantile period he believes great caution should be exercised in the administration of this drug.

James W. Walker mentioned the use of the **Paquelin cautery in the treatment of neuritis**, saying that he had obtained excellent results in the relief of pain. He could say nothing regarding its effect upon the inflammatory process in acute neuritis. It seemed formidable to the average practitioner to see it used. The lightest possible touch was all that was necessary. It could be used once daily, or once every other day, two or three strokes being made in the vicinity of the pain, affected joint or nerve.

Thomas L. Gilmer said he had been a suf-

ferer from neuritis, especially of the sciatic form. A short time ago Dr. McArthur gave him a prescription for local application which did him more good than any one thing he had used for a number of years. This prescription was: Menthol, 8 grams; oil of gaultheria, 30 grams, and creosote, 2 grams.

Dr. Kuh, in closing the discussion, agreed with Dr. Montgomery that rheumatism and a number of other causes might produce neuritis, Bright's disease amongst others.

With reference to the remarks of Dr. Grinker, he said that if his (Grinker's) patient had paresis of the lower extremities, associated with total paralysis of the movements of the eye-balls, the patient probably did not suffer from a diphtheritic neuritis. Total paralysis of all of the extrinsic muscles of the eye-ball could hardly occur in neuritis.

C. H. Lodor,  
Official Reporter.

The Chicago Academy of Medicine met May 9th. R. B. Preble was elected chairman. The incoming directors (Baum, Evans, Kiernan, Moyer and Talbot), were inaugurated. Baum, Gehrmann, Moyer, Hallberg and Preble took part in a discussion of the question **whether physiologic tests should be admitted into the pharmacopoeia.** The consensus of opinion was in favor of their admission as regards the serums, but opposed to their admission otherwise. At the June 27th meeting A. E. Baldwin was elected chairman. R. B. Preble, who opened a discussion on **Diabetes Mellitus**, pointed out that the conditions grouped under diabetes and glycosuria had a varied symptomatology. This was due to the way in which the organs were affected and to the complications therefrom resulting glycosuria and diabetes were not interchangeable terms. Glycosuria might be an expression of various conditions which in themselves were not nosologic in the sense of diabetes. There might be an alimentary glycosuria due to an excessive employment of carbohydrates. More than two per cent of sugar is an indication of probable diabetic outcome. There were two types of diabetes; one severe and apt to be fatal, while the other ran a comparatively mild course. In the severe type neuralgiae especially of the sciatic region, were frequent. Headache, mental dullness and apathy were likely to be precursors of the severe type. The question of renal inadequacy played a part in determining these phenomena. Diabetes after fifty except as a complication was not apt to be severe. The essential nature of diabetes was not yet settled. The condition, however, might be a disease *per se*, or might be a complication or symptom of other conditions.

J. Frank never operates until the urine is examined and it is determined by diet whether the diabetes is intermittent or continuous. Care should be exercised where sugar is always present. The great danger of diabetes in surgery is not the diabetes *per se*, but the conditions tending to form culture media for pathogenic bacteria. Most of its dangers can



be overcome by proper antiseptic and aseptic procedures. Union by first intention is undesirable and bad practice. In cases where diet is without effect on the diabetes extreme care must be exercised. Such cases readily become necrotic. It is good practice to keep the wounds open and to use mild antiseptics like boric acid. Operations on bones are especially dangerous.

W. A. Evans finds the polariscope the best test for sugar. The copper test seldom fails but reacts to other substances than sugar. There are many conditions in which glycosuria occurs which are quite common but which do not become diabetic. In many business men sugar appears on mental strain to disappear on relief from this strain. The popular belief in the dangers of glycosuria from business strain quite wide spread among Chicago business men, leads them to have frequent uranalyses. The primary pathology of diabetes was still in the same obscurity it had been for many years. Recent researches on the pancreas had thrown light on some types which had been demarcated as pancreatic many years ago. That glycosuria was an expression of nervous disturbance of metabolism there was much evidence to show.

A. C. Cotton called attention to the fact that diabetes was rare in the extremes of life. The disease seemed to be increasing among children but this was due to the increased employment of uranalysis in diagnosis. There was an apparently greater amount of diabetes among children in Chicago than in New York. This was however due to the fact that the Chicago statistics covered the last four years when uranalysis was becoming frequent, while the New York statistics covered a much longer period. There was a seeming expression of heredity in certain cases. This was rather an expression of maldevelopment than of direct heredity. Diabetes occurred in children after jaundice and after scarlatina. As a rule diabetes in children had a fatal prognosis quite in contrast with the favorable prognosis of senile diabetes.

W. L. Ballenger pointed out that opinions differed as to ear, nose and throat conditions produced by diabetes. Any specific disorders due to diabetes had not been clearly demarcated since other causes usually co-existed with diabetic states. Diabetes however frequently aggravated any morbid condition of the ear, nose and throat. In operations on these regions the fact should be remembered that diabetic coma was readily superinduced by anaesthesia, which brought on the acid state that underlays coma.

E. S. Talbot pointed out that the gums and teeth were very early affected in the disease. The alveolar process being a transitory structure readily yielded to any toxemic state. As the arteries terminated at the base of the teeth, they readily decayed and the dentine cut like horn. The vinous odor of diabetes might occur in the mouth long before other conditions were evident. The early shrinkage of the gums at the outset of diabetes and of diabetic

coma had been pointed out by Tyson two decades ago. The conditions of the gums antecedent to toxemic states deserve further study.

W. H. Wilder stated that the most marked effect of diabetes on the eye was seen in the crystalline lens. This was an epiblastic structure which like epiblastic structures generally, teeth, nails, etc., was readily effected by toxemic states. Cataractous states resulted which did not resemble senile cataract. Diabetic cataract was not frequent. While glycosuria did not contraindicate operations on double cataract still the outlook in diabetic cataract proper was not promising. Unlike general surgery primary union was for obvious reasons necessary in ophthalmic surgery. Diabetic retinitis is frequent and may occur in an exudative and a hemorrhagic type. Sometimes it is difficult to determine the lesions since they exist in the periphery of the eye ground. Uranalysis for sugar should always be made where hemorrhagic retinitis or small haemorrhages associated with a white exudation are found around the macula. As a rule the retinitis is symmetrical, but to this there are some exceptions.

D. R. Brower pointed out that of necessity there was no specific for diabetes, since conditions indicating treatment were manifold and needed relief more than the glycosuria per se. Insomnia was a distressing symptom which often yielded to hydiatic procedure. He had found chloral hydrate and sodium bromide of value. Trional and sulphonal might set up kidney strain and hence were often contra indicated. All cold tar preparations were dangerous because of their tendency to produce cardiac depression. In constipation which tended to increase diabetic discomfort aloetic purges and colonic flushings were indicated. He had seen extreme obstipation followed by a faecal tumor produce temporary diabetes which disappeared on colonic flushings that removed the tumor. Rigorous diet was injurious. The distress produced worst results than the benefit from decreased glycosuria could compensate for. All of the alternatives had proved of benefit in luetic, lithemic and allied states. Gold chloride and guaiacum were of benefit. Pancreatine and papain were of service. Where opium is indicated the extract of opium was preferable to morphine. Jambul was at times of service. Thyroidin and adrenalin were of doubtful value in most cases. Diabetic patients should always be watched for the appearance of acetone, diacetic acid and oxybutyric acid which indicated the onset of coma. Here sodium bicarbonate should be given in great quantity hypodermically if necessary. Potatoes were allowable because of the quantity of water they contained and also because they tended to increase alkalinity.

W. L. Baum stated that among dermic states were sometimes to be noted bronzing of the skin and allied states. These were comparatively rare. Eczema was much more frequent and accompanied with itching and burning of the labia and vicinity was sometimes met with in women incident to fre-

quent micturition. The meatus urinarius in the male was similarly affected. Boils, furuncles and carbuncles were of extremely frequent occurrence. Furunculosis and pruritus should always lead to uranalysis. Unilateral sweating at times occurs. Xanthoma elsewhere than on the eye indicates glycosuria. In diabetic gangrene ergot was sometimes of service through its constitutional effects in decreasing glycosuria. In prostatic and vesical irritation of glycosuric origin it was often of value. Diabetes mellitus edema is not necessarily the result of renal changes, but is usually an expression of anemia.

J. Frank called attention to a class of toxic states presenting all the symptoms of diabetes except glycosuria and polyuria. These cases were bad subjects for operations.

C. S. Hallberg pointed out that extract of opium contained the tonic principle narcotine which affected beneficially the influence of morphine.

J. G. Kiernan said that glycosuria, diacetic acid and beta-oxybutyric acid and acetone often appeared during the quiet and depressed periods of certain psychoses. In depressed psychoses there was marked wasting as well as decided irregular metabolism. Sometimes cases occurred in which the patient was sane during the glycosuric period and insane during the period when sugar was absent from the urine. Glycosuric states sometimes took the place of epileptic attacks. Acidosis (as Naunyn had called the acid state underly-

ing coma), often coincided with the apoplectic attacks of parietic dementia. Some of the crises of locomotor ataxia were accompanied with glycosuria. What might be called the neurasthenic neuroses of diabetes mimicked everyone of the great neuroses. Tabetic reflexes including the light reflex were sometimes found in diabetes. The amount of urine passed at the onset of coma was sometimes enormous. Some of the English clinicians had observed cases in which four gallons had been passed *per diem*. The largest amount he had observed was three gallons. He had found strychnine to be of value the air hunger which is such a marked feature of diabetes as well as other suboxidation states. Heroin in one-sixteenth grain doses was an excellent substitute for morphine since it locked up the secretions less, quieted the general irritation better and decreased the sugar more. The general mental state of the diabetic was a capricious, apathetic, good humored irritability. This state like the slightly similar but more suspicious state of the consumptive, interfered greatly with continuity of treatment. Sometimes the coma was disguised as a stuporous melancholia in which the seemingly unconscious patient had psychic nausea depressing delusions and depressed emotionality. It was in just such a case that opium acted well and heroin had here shown itself the best of the opium preparations.

J. G. Kiernan,  
Official Reporter.

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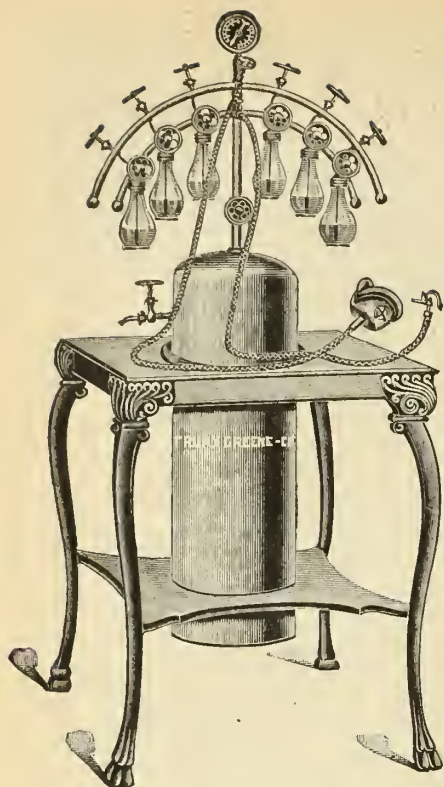
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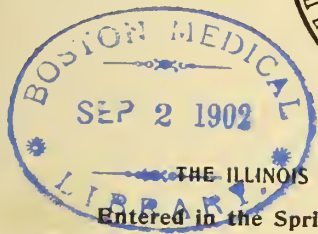
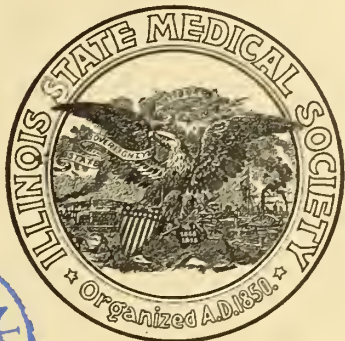
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THE ILLINOIS STATE JOURNAL COMPANY.

Entered in the Springfield Postoffice as Second-Class Matter.

Volume LII.  
New Series, Vol. IV.  
Number 4.

Springfield, Ill., September, 1902.

{ Subscription, \$3 a Year.  
Single Copies, 25 Cents.

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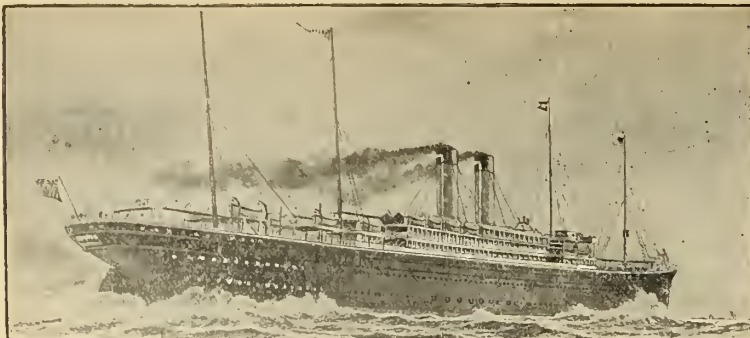
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VOL. LII.  
New Series, Vol. IV. }  
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Springfield, Ill., September, 1902.

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## VOLUNTARY NYSTAGMUS?\*

J. WHITEFIELD SMITH, B. S., M. D., BLOOMINGTON.

Lecturer on Physiology and Hygiene Illinois Wesleyan University; Oculist and Aurist to the Chicago & Alton Railway Co.; Ophthalmic and Aural Surgeon to the Brokaw Hospital.

The ease of so-called Voluntary Nystagmus, which I have the privilege of reporting to the Society, is not one of pathological significance; but perhaps, may be of interest from a physiological standpoint. When we consider the derivation and meaning of the terms, which are used to designate the subject of my paper, it will become obvious, that they do not represent, adequately, the conditions of the phenomenon presented. Nystagmus, is derived from a Greek word Nustagmos from Nustazein, to nod; and is associated with the idea of the head nodding in the act of falling asleep, and also, of nictitation, or the involuntary winking of the eyes in a drowsy or slumbering condition. The idea of the word in its origin perhaps is contained in the expression: "He nodded his assent to the king, etc." This seems to be its philological construction.

Nystagmus in its pathological consideration is used in the following manner: "This affection is characterized by tremulous movements of eyes, whose mobility is not otherwise impaired. These movements are involuntary, exceedingly rapid, almost rhythmic, and affect both eyes at the same time." Stellwag.

"Nystagmus, involuntary oscillating movement of the eyes etc." Nettleship.

"This term is applied to a condition characterized by an involuntary rapid movement of the eyeballs." DeSchweinitz.

"Nystagmus is a peculiar oscillatory movement of the eyeball, entirely beyond the control of the patient, which becomes worse by

excitement or accommodative effort." Mitendorf.

The thought which I wish to emphasize in these definitions is that the movement of the eyes is involuntary. The use of the term nystagmus, in medical literature conveys the idea of an involuntary act or condition. Then, to use the terms "voluntary nystagmus," to describe an oscillating or tremulous movement of the eyes, wholly under the control of the will, that is, which can be produced at any time and stopped at any instant, is, to say the least, very awkward phraseology. It is the equivalent of the expression: "A voluntary involuntary movement of the eyes." Voluntary Nystagmus is not only a confusion of terms, but is illogical. This is evident from the "law of contradiction"—one of the primary laws of thought—which means that nothing can have at the same time and at the same place contradictory and inconsistent qualities. The movements of the eyes are either controlled by the will or not controlled by the will; they are either voluntary or involuntary. Therefore, if nystagmus is an involuntary movement of the eyes, it is inconsistent and illogical to speak of a "voluntary Nystagmus." The unique phenomenon of oscillating or vibrating the eyes at will, which power, a few individuals possess and which indeed, simulates a nystagmus is in reality not a nystagmus at all. It is physiological rather than pathological, and should be designated by a comprehensive term in the nomenclature of medical science. In this connection, and in view of these facts, I would very respectfully suggest to the members of the Illinois State Medical Society, for their favorable consideration, the following term viz: Ophthalmodonesis, and would define it, as a voluntary tremulous or oscillatory movement of the eyes. I shall now endeavor to describe this characteristic manifestation in the report of a case.

Mr. DeF., age 21, student in the Illinois

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

Wesleyan University. Nativity; his father is a descendent of the French Huguenots, and his mother is of English parentage. He has a brother 23, and a sister 17 years old respectively. The father is 46 years old and in good health. His mother died at the age of 30 of Typhoid fever. The brother and sister are in health, and there has never been any eye trouble so far as can be obtained, in the family history, except that the sister had an apparent convergent strabismus of the left eye in near vision, but the eyes were normal when she would direct them in distant vision. Patient had some slight inflammation of the eyes when he was 7 or 8 years old; as he remembers, some solution was instilled into the eyes for a few days. The patient has the ability to make both eyes vibrate rapidly and at the same time in the lateral direction, or in the horizontal plane. This act is volitional, being wholly under the control of the will. He seems to be able to inaugurate these movements at any time he chooses, and stop them accordingly. I have repeatedly examined the eyes and find no pathology whatever. The acuteness of vision, field of vision, range of accommodation, muscular balance, and the color sense, all appear quite normal. Ophthalmoscopic examination is negative. There are no opacities in the refractive media, nor malformation of the globe or orbit that I have been able to discover. The innervation of both the intrinsic and the extrinsic muscles of the eyes appear quite perfect and the patient has no trouble in distant or near vision; and can use his eyes for long periods of time, at close range without pain or inconvenience. At this juncture I might also mention that the patient can arch the right brow independently of the left, or rather can arch the right brow and draw the left one down at the same time. He can also close the left upper lid over the eye, without wrinkling the forehead, or the skin of the eyelids. Apparently, the upper lid falls gently and smoothly down over the globe of the eye, while the right eye remains open. Furthermore, he can vibrate the alae of his nose very rapidly and move either ear. All of these movements are wholly under the

control of the will. The manner and circumstances under which he can vibrate the eyes is worthy of notice. The eyes vibrate or oscillate only in one direction—in the horizontal plane—but, he can produce this motion not only with the visual line in the primary position but in any secondary position. In extreme convergence, in extreme divergence of either eye, and in looking upward and downward. The tremor can be kept up during the entire excursion of the eyes. (circumduction.) The eyes may be made to vibrate when the lids are closed, and also while the patient looks through a No. 20° prism placed before either eye with its base in any direction. The patient can arch the brow, vibrate the alae of the nose, and oscillate the eyes all at the same time. The vibration of the eyes can be kept up for about one-half minute. The longest period of time that I have observed it was thirty-five seconds. The feeling in producing this motion is that of a slight pressure behind each eye, pushing them or pressing them forward. It is well known that the globe of the eye projects from the orbit about a millimeter in forced innervation of the levator muscle of the lid, generally when the visual lines stand horizontal and parallel to one another. This I have observed in this patient. Ordinarily when he produces these oscillations of the eyes, the palpebral fissure is a little wider than when the eyes are opened naturally, the upper lids are a little unsteady, and the eyes slightly protrude. I have never observed any changes in the pupils during the oscillations. As a matter of fact, any object viewed by the patient, when the eyes are vibrating, has a simultaneous movement. The objects in a landscape all appear to be constantly changing their position, and near objects seem to be doubled and blurred. For instance, a ball suspended by a cord at a distance of 10 ft. appears as two balls about 12 inches apart, continuously approaching and receding from each other, the intervening space being blurred and indistinct. This appearance of double objects approaching and receding with an indistinct space between them is illustrated when we direct our eyes in the following manner: suspend a small ball



by a cord at a distance of 10 ft. from the observer's eyes and another in a direct line at a distance of about 100 ft. When the observer looks at the near ball, with the idea of the further one also coming into view, the further one is doubled and they appear to approach each other and then recede. If with the balls suspended as above we attempt to look at the distant ball with the idea of bringing the near one also into view, the near ball appears doubled and seems to remain about stationary. When the patient vibrates his eyes and fixes an object, it seems double and they appear to approach and recede as in the first illustration. The patient can produce these oscillatory movements in daylight or in darkness, or in the presence of artificial light with equal energy and rapidity. The amplitude of the vibration is about one millimeter and the rate of movement perhaps 5 or 6 a second.

William E. Gamble of Chicago reported a case to the Chicago Ophthalmological and Otological Society in December 1896, which is very similar to my case. Since the literature is so meagre in regard to these cases, it will be interesting to review this one. The case is published under the name of Voluntary Lateral Nystagmus, in "The Journal" (A. M. A.) March 4, 1899, A. D., age 24, German-American, a medical student, has been a student and teacher all his life; has not been sick since childhood; had no severe illness during that period. He did not have scarlet fever nor diphtheria, and has never had diseases of the eyes of any kind. While attending high school at about the age of 15 years, he first discovered that he could produce at will lateral nystagmus, and afterward often amused his classmates by his optical gymnastics. It was never involuntary. He has never experienced any difficulty in starting the eyes going but can continue the movement less than a minute, as the muscles become exhausted. He can not produce it in one eye alone. Nystagmus is most pronounced when fixing the eyes on an object six to eight feet distant, directly in front, but can continue at less rapidity when the eyes are making the lateral excursion. The movements are more pronounced by daylight than by artificial light. The

rapidity of movement is as great as I have ever seen in cases of nystagmus. V. each eye  $\approx 20/20$ . He does not suffer from headache nor eyestrain by continued study. He is not subject to headache of any kind. He accepts R. E. Cyl. 50 D. axis 180  $\approx 20/20+2$ . L. E. Sph. .25 D.  $\approx 20/20+1$ . There is no opacity of cornea nor other media. Field of vision is normal, color sense is normal, and fundi are normal in appearance. He has never had writers' palsy nor other manifestation of neurotic disease. He has never worked in mines nor lived in a mountainous country. The case is unique on account of its great rarity. Dr. Noyes, however, in his "diseases of the eye," edition of 1896, says that he has seen but one case of voluntary nystagmus the patient having acquired this movement after having been confined to his room for some weeks, for eye trouble. This case of Dr. Noyes is the only case I have seen reported. There is scarcely any literature upon the subject, and I have not yet seen any explanation offered accounting for the phenomenon. In this case there is no new movement acquired differing from the normal lateral movements of the eyes, save that there is greater rapidity of motion. Why this man possesses this rare faculty, while millions of his fellows do not, is a problem for speculation. There is evidently no pathology here. There is no want of cortical innervation of extraocular muscles, rather a temporary amount of it. Opacities of the cornea or other refractive media of eyes, when occurring in early childhood, may produce nystagmus proper, volition being the only cause in this case.

Dr. Gamble refers to the case of the late Dr. Noyes which he saw through the courtesy of Dr. Williams of Boston, a few years ago. Dr. Fuchs says in his text-book of Ophthalmology: "There are also men who can produce nystagmus voluntarily." These cases to which I have referred are all that I have been able to find written on this subject.

The *Modus Operandi* of these co-ordinated movements is problematical. Adamuk has established the existence of definite centers of co-ordination. His physiological experiments show that the centers of co-ordination

for the movements of the eyes, lie especially in the corpora quadrigemina of the brain. His research has led to the following results:

(a) Irritation or stimulation of the corpora quadrigemina produce symmetrical movements of both eyes.

(b) Irritation of the right half of the corpora quadrigemina produce movements of both eyes to the left.

(c) Irritation of the left half of the corpora quadrigemina produce movements of both eyes to the right.

(d) Irritation of different points of each half of the corpora quadrigemina produce many movements of both eyes at the same time and in the same direction.

(e) Continued irritation of the corpora quadrigemina causes the head to turn toward the same side as the eyes.

(f) Divide both halves of the corpora quadrigemina in the median line and the motion is limited to the side of irritation.

(g) Irritation of the middle of the anterior portion of the corpora quadrigemina in the posterior commissure—Divergent axes immediately become parallel.

(h) Irritation between the corpora quadrigemina, posteriorly produce movements of both eyes upward with dilatation of the pupils.

(i) Irritation between the corpora quadrigemina more posteriorly produces upward motion becoming more convergent.

(j) Irritation of the posterior inferior part of the corpora quadrigemina, extending to the floor of the aqueduct of Sylvius produce greater divergence, inclination downwards, and contraction of the pupils.

(k) Irritation (probably) at the base of the corpora quadrigemina causes a sinking of the line of vision with parallel axes.

(l) Simultaneous irritation of both anterior corpora quadrigemina produce movements such as are observed in nystagmus.

(m) Irritation of the posterior corpora quadrigemina especially in the middle, produces great dilatation of the pupils, and a horrible expression.

I have been able to verify some of these results in the laboratories of the Illinois

Wesleyan University, by the assistance of Prof. J. Culver Hartzell, Department of Biology, and J. K. P. Hawks, lecturer on Physiology and Hygiene. The experiments were made on the brain of the cat with the following observations: the calvarium being carefully removed, electrical stimulation was applied by means of a fine needle electrode attached to a chloride of silver dry cell battery. The strength employed was from five to eight cells. The point of the needle being introduced into the region of the co-ordinating centers at different points and by completing the circuit, with the other electrode placed in contact with the muscles of the neck, responsive movements of the eyes were observed in several directions. A needle electrode introduced into the region of the precentral gyrus and extending downward backward and inward, through the hemisphere to the base of the brain as shown in the following cut, produced nystagmatic movements of the eye on the same side. The movements were about a centimeter in extent and quite rapid.



The brain of the cat. Natural size. The dark spot shows the point of emergence of the electrode at the base of the brain.

The co-ordinating nervous mechanism for the complex and carefully adjusted movements of the eye consist essentially of three factors, a mechanism for the conduction of afferent impulses, efferent impulses, and volitional impulses.

Visual impulses.

The processes which give rise to visual impulses begin somewhere in the region of the rods and cones in the retina. The impulse is carried backward along the optic nerve to the chiasm, and thence along the optic

tract to the three primary visual centers or the chief endings of the optic nerve in the lateral corpus geniculatum, the pulvinar and the anterior corpus quadrigeminum. There is probably a fourth ending in which some fibers pass directly back from the optic tract to the cerebral hemispheres. No doubt the visual impulses are modified in the primary visual centers and pass onward in their course to the higher visual centers of the occipital cortex by means of the optic radiation, as crude visual sensations; ultimately, to be further elaborated and translated in the realm of consciousness. There seems to be a double connection between the higher visual centers of the cortex, and the lower, or primary visual centers; the fibers coursing in either direction through the corona radiata.

#### Efferent impulses.

Coordinated efferent impulses originate in the nuclei of the three nerves supplying the ocular muscles, namely the third, the fourth, and the sixth. The impulse is carried along the nerve to the respective muscle, which it innervates. The important points to note in this connection are, (a) some of the fibers derived mainly from the nucleus of the sixth nerve, which supplies the external rectus muscle, pass out along with the fibers of the third nerve to the internal rectus, so that the nucleus of the sixth thus supplies both the external rectus of the same side entirely, and the internal rectus of the opposite side partially, (b) the nucleus from which the third nerve takes origin, extends upward beneath the superior corpora quadrigemina, and the issuing fibers pass through the tegmentum of the crus, (c) stimulation, not only of the nuclei, but also of the nerve fibers in their course to the muscle, or of the muscle itself, produce contraction.

#### Volitional impulses.

Volitional impulses in the region of the cortex, in some way, are concerned in the coordinating movements of the eye. The impulse is carried along the medullary fibers, but the paths of conduction have not been so well determined, as in the case of afferent visual impulses, or of efferent impulses. In the projection system, fibers

pass from the spinal cord, medulla oblongata, and pons varolii to the cortex of the hemispheres, or vice versa.

"The fibers which pass to the cerebrum in the tegmentum, are originally constituted by the longitudinal bundles of the formatio reticularis of the medulla oblongata. They are reinforced as they pass upwards by sets of fibers derived from the superior peduncle of the cerebellum and perhaps the middle peduncle; from the fillet; from the deeper parts of the corpora quadrigemina, and from the nerve and other nuclei in the parts which they traverse. They become lost for the most part in the subthalamic tegmental region and in the thalamus, but on the other hand, from the outer side of the thalamus fibers stream outwards, and joining the general system of the corona radiata, diverge to nearly every part of the hemisphere. Other fibers, apparently continuous with this same system, pass from the posterior part of the thalamus into the optic tract." Quain's Anat.

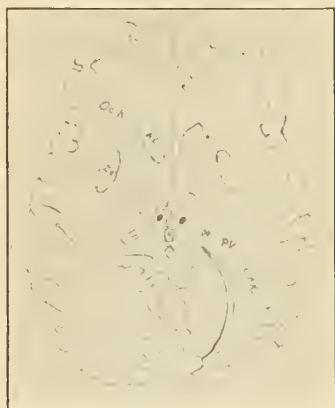
"The fibers of the tegmentum are continuous with those longitudinal fibers of the pons which are derived from the formatio reticularis of the medulla, which is formed by fibers from the olivary body, lateral and posterior columns of the cord, and the superior peduncle of the cerebellum. They are reinforced by fibers from the quadrigemina and corpora geniculata, and enter the optic thalamus, in which many terminate and, from which others arise; others pass through the body, and with those fibers arising in it, spread out to form the corona radiata, especially joining the ganglion-cells of the cortex of the temporo-sphenoidal and occipital lobes." Gray's Anat.

"The corpora quadrigemina receive fibers from the cerebellum through the processus adtestes, from the olivary fasciculi and the optic tracts and third nerves." Foster's Physiology.

From these authorities it is evident that the cortex of the hemispheres are in connection with the coordinating centers for ocular movements, namely, the corpora quadrigemina, and also with the nerve nuclei supplying the ocular muscles. We may thus describe a Z—tract, the fibers of which ex-



tend from the neighborhood of the precentral sulcus—the motor area for the eyes—downward between the caudate nucleus, and the lenticular nucleus, (probably some fibers pass through the corpora striata) thence through the thalamus to the corpora quadrigemina and to the nuclei of the third, fourth, and sixth nerves. These fibers connecting the frontal cortex with the three ocular nerve centers, may be regarded as the ‘ocular radiation:’ in contrast to the fibers which connect the occipital cortex with the three primary visual centers, which are known as the ‘optic radiation.’ The medullated fibers of the Z tract, constituting the ‘ocular radiation’ is illustrated in the following cut.



Diagrammatic: NC. nucleus caudatus, LN. nucleus lenticularis, TH. optic thalamus, AQ. anterior quadrigemina, PV. pulvinar, GL. lateral corpus geniculatum, Op. R. optic radiation, HVS. higher visual centers, 3, 4, 6, nuclei of the third, fourth and sixth nerves, OC. R. ocular radiation of the “Z tract,” OC. M. motor area for the “ocular muscles.”

Having noticed the paths of conduction through which afferent visual impulses, efferent impulses, and volitional impulses travel; it seems that through them all ocular movements are effected. No doubt, the centers of coordination are reflex in character to a certain extent, and that movements of the eyes are inaugurated by the joint action of impulses or sensations coming to the centers along different routes; or perhaps inhibitory impulses travel along one route, while stimulating impulses travel along

another in producing the varied and complicated movements. The action in some respects is wholly voluntary while in others it is involuntary. The involuntary action is illustrated in the common glance in which an object is suddenly brought into the field of vision in an oblique direction. The eyes instantaneously are directed toward the object. It is further illustrated in the tremulous or oscillating movements, or of the eyes in the lateral direction, which simulates a lateral nystagmus, when one looks from the car window of a rapidly moving train, at the objects in close range. The eyes vibrate rapidly in the horizontal plane, due to the fleeting images before the retina and the inability to “fix” them for any considerable time.

Voluntary action is illustrated in the ability to move one eye independently of the other. This would indicate an inhibitory action of the one eye, with the volitional potential energy in the other; and thus, the coordinating centers of the two eyes must be influenced along different paths or by different stimuli, or by cortical impulses coming from different areas. Foster says, “very few persons are able by a direct effort of the will to move one eye independently of the other, though some and among them one distinguished both as a physiologist and an oculist, have acquired this power.”

J. E. Colburn of Chicago has kindly furnished me with the report of a case which well illustrates the independent voluntary movement of one eye. “Mr. G. aged 28, an engraver, always used his loup over the left eye and distributed his tools to his right side. He was accustomed when the loup was in position, to use his graver with his left hand, and pick up any tool that he desired upon the table near him, without changing the relation of his eye to his work. As a result of this over accommodation and irritation, he had an attack of cyclitis, in his right eye, first, eight years ago, again five years ago and again two years ago. Each attack was very protracted, and each one longer in duration than the one preceding. I desired him to use a binocular loup, instead of the monocular which he was accustomed to use, and break himself of the habit

of picking up tools and estimating distances with the uncovered eye, in case he used the single eye piece. He had also acquired the habit of fixing with his left eye and rotating his right eye in any direction that he desired, though not as rapidly and with as steady a movement, as he did when the loup was in position." In this same connection Dr. Colburn mentions another interesting case, showing the power of inhibition, or of volition: "Mary T. aged 18, was thrown from a cart in a runaway and sustained some injury to her head. Following the injury she had a rotating nystagmus, which she could perfectly control by her will power, and yet when her attention was unfixed, the movements were continuous and considerable."

It is generally accepted that visual sensations influence all of the various movements of the eyes. That is, efferent motor volitional impulses are originated or are preceded by afferent visual impulses. If the eyes are moved we must either look at or for an object. It certainly is apparent in the case I reported that the patient does not depend on visual sensations for the movement of his eyes. He can produce the movements without looking at or for an object, either real or imaginary, indeed can produce the movements with his lids closed, or in the dark, or without "fixing" an object. Likewise he can produce the movements of his eyes when he "fixes" an object at near range, or in the distance. This would seem to show the independence or volitional character of the movements, and thus by elimination, we may exclude "Visual Sensations" as a factor or an element in the causation of the movements of the eyes in this particular case. Again, if this be true, efferent motor volitional impulses are not wholly dependent on afferent visual impulses. The movements in this case, no doubt, are dependent on efferent impulses effecting the nerve centers controlling the ocular muscles, or perhaps the coordinating centers of the corpora quadrigemina in which case, if they are not due to visual impulses, they must be connected with the kinaesthetic or psycho-motor centers of the cortex.

In some species of the monkeys, notably

the species of Macaque (*Macacus Sinicus*) electrical stimulation on the surface of the cerebrum, in front of the precentral sulcus, produces contraction of the ocular muscles, and the region is known in cerebral localization as the "motor area for the eyes." We may infer a corresponding locality in the human brain, since the centers of the cortex are somewhat similar.

The movements of the eyes are not confined alone to electrical excitation in the motor area of the frontal lobe, for movements may be produced by stimulating the occipital cortex in the region of the higher visual centers. In this case the conduction is through the "optic radiation" to the lower centers. In the former, however, the impulse or sensation must travel from the kinaesthetic centers of the frontal cortex to the lower centers along contiguous medullated fibers which we have already described as the "Z tract" or "ocular radiation." In support of this we may note the following as a summary.

1. In the projection system the anatomy seems to show the connection between the cortical centers of the frontal lobe with the ganglionic centers of the thalamus and of these with the nuclei of the nerves of the ocular muscles, and also with the coordinating centers.

2. That the thalamus is an important basal ganglion not only originating fibers, but also a kind of way-station or internode through which fibers pass to and from the cortex.

3. In the "Z tract" or "ocular radiation" fibers stream outward from the side of the thalamus. Their course through the thalamus is shown by the transverse markings of the medullary fibers in the anterior, external and posterior nuclei.

4. The response in activity of the ocular muscles under the influence of electrical stimulation in the region of the precentral sulcus.

5. Nystagmatic movements have been produced by passing a probe into the region of the corpora striata and optic thalami.

6. Incoordinated movements of the eyes are never intimately connected with lesions

of the upper and more peripheral parts of the brain.

7. Cerebral-hemorrhage involving the basal ganglia often produce conjugate deviation of the head and eyes toward the unparalyzed side.

8. Conjugate deviation of the eyes occurring as a symptom of cerebral lesion in the region of the basal ganglia is usually indirect and transitory, showing a temporary disturbance only in the tract of fibers connecting the cortex with the center of the brain.

On further research of the literature on this subject (by the courtesy of F. S. Crocker) I find a reference of the report of a case by H. Work Dodd. *Oph. Rev.* vol. 19, p. 330, 1900.

Pick's text book states, "many healthy patients can voluntarily produce nystagmus."

Also in the *Chicago Medical Journal and Examiner*, Nov. 1881, I find the following: Voluntary Nystagmus, by George Lawson, F. R. C. S. (*Oph. Hosp. Rep.*, vol. 10, p. 2.) Reports the case of a gentleman who at will could set both his eyes into a rapid lateral motion. The movements were an exaggeration of what is seen in lateral nystagmus, they were so rapid however, that the margins of the cornea could not be defined.

## THE PSYCHOSES IN BRIGHTS DISEASE.\*

BY C. BARLOW, M. D., ROBINSON.

Mental disturbances may become manifest in every variety of nephritis, but are observed most frequently in the chronic forms of the disease. It is in interstitial nephritis that delirious uraemia and the different forms of insanity are most frequently observed. Next in frequency are the mixed cases. The nephritic psychoses (I use the term in it's broadest sense) as usually observed may for convenience of study be divided into four groups some of which may be subdivided. The first group consists of those cases in which the mildest form of mental disorders,

consisting in loss of memory, confusion of thought, irritability, obstinancy, and occasionally mild delirium with temporary loss of consciousness. In these cases the mental disturbances are so mild that they are scarcely noticeable by the casual observer. Even the physician who is not constantly on the lookout may not detect these phenomena. But if he is looking for manifestations of mental weakness he will rarely fail to find them in any case of chronic nephritis and in many of the acute cases.

It is not unusual to hear these patients say, "I can't think, I cannot remember, my mind is confused," and sometimes they will tell you that they are delirious at times, and it is not unusual for them to be unable to recall visits made by the doctor the previous day. This may be the first sign given by them of mental weakness. They may converse freely with you, and seem to possess their usual mental activity and on the following day have no recollection whatever of your former visits. They seem to realize that their minds are disturbed, but they cannot overcome the difficulty no matter how hard they try. These patients will improve however if the toxic materials can be removed by treatment and there will be no difficulty for a time, but there most certainly will be a return of the symptoms sooner or later, and in some cases much more severe, while others may not manifest any serious mental disturbance until near the end, when perhaps the majority either become comatose or delirious.

The second group of symptoms come under the head of acute uraemia, attacks of which sometimes occur in chronic Brights disease. The symptoms are varied and much more severe, manifesting themselves in the form of delirium, convulsions or coma.

These symptoms result from intense toxæmia, and may be transient and recovery from them complete or they may be signals for a speedy dissolution. In the third group the symptoms present are those of insanity and are regarded as manifestations of a chronic toxæmia progressing slowly until the mind is dethroned. This form of mental disturbance is known as chronic delirious

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.



uraemia or uraemic insanity. It usually manifests itself in the form of melancholia, mania or dementia, and when the kidney disease is well advanced and in individuals who have no special tendency to insanity. This form of psychoses usually occurs late in the course of chronic interstitial nephritis and the patient may live but a short time.

The fourth group of mental symptoms occur in the form of actual insanity in patients who have hereditary tendencies to insanity, and the mental phenomena are those observed in the different forms of insanity and probably occur more frequently than we have been led to believe by the literature of the subject. This form of insanity occurs in patients who are predisposed by heredity and in whom the nephritis acts as an exciting cause. The insanity may become manifest much earlier in these patients because it requires but a slight impression on the brain to bring on the attack.

As a result the nephritis not being far advance, possibly in it's incipientcy, it is fair to presume that some of these patients are adjudged insane and are sent to the asylum before the nephritis is recognized.

It is well understood that disease of the kidneys is frequently observed in the insane, judging from the literature of the subject about fifty per cent of the insane have disease of the organs. "Bristowe observed that out of a total of 3,446 cases of insanity 48.8 per cent had renal disorder of some nature, while of 266 cases general paralysis 68.8 per cent showed signs of renal trouble." "Dr. L. E. Batten says; that an examination of 1034 patients showed that in 60 per cent albumin or casts were present." Worcester says; "cases in which insanity is due simply to disease of the kidneys are rather infrequent in hospitals for the insane. Taking the term Brights disease in it's broadest significance, however, it is probably one of the most common causes, if not the most common of mental derangement."

"Dr. Hyslop concludes that renal disease is associated with insanity in two ways, (1) acute transient delirious mania, an acute toxæmia, or uraemic insanity, and (2) a

progressive cerebral degeneration, with chronic renal disorder as the result.

It seems that the observations given above are somewhat convincing as to the frequent co-existence of Brights disease in it's broadest sense, and insanity but their relationship is not yet entirely understood or at least there seems to be a difference of opinion among those who have studied the subject as to whether Brights disease is a prominent factor in the etiology of insanity or whether the insanity of Brights disease is only a delirious uraemia simulating some of the different forms of insanity.

I believe, however, that uraemic insanity manifests itself most frequently in persons not predisposed to insanity by heredity while on the other hand those who inherit insane tendencies are often thrown into attacks of insanity by the presence of Bright's disease just as soon as the resultant toxæmia begins to manifest itself. The causes of cerebral disturbances in nephritis are, uraemia, or toxæmia from various sources, arterio sclerosis increased arterial tension, anaemia of the brain, dyspnoea, and it's causative factors, as hydro thorax, oedema of the lungs, and disease of the heart. The above all contribute as disturbers of mental activity in the course of Brights disease. The causes mentioned act as disturbers of mental equilibrium through their influence upon the circulation and by interfering with the proper oxygen action of blood and the consequent anaemia and oedema of the brain or by the rupture of a diseased blood vessel, these are all the probable results of renal inaequaty, other views have been held regarding the origin of the disease. One theory is that in Brights disease the nephritis is not the primary affection, but it's secondary to diffuse changes in the blood vessels throughout the body. For our purpose it matters little whether the primary lesions are in the kidneys or blood vessels, we know that toxæmia results. The blood is loaded with poison which tends to disturb the nutrition of the brain and to deprive it of it's normal supply of oxygen and cannot fail to interfere with mental activity and most certainly does weaken the mind and cause all kinds

of mental disturbances from the mildest form of mental weakness, and the most severe outbreak of delirious uraemia to actual insanity of the severest type.

This subject is of importance from a clinical standpoint because if we recognize the real trouble we can do a good deal for some of these patients. Uraemic insanity should generally be treated at home, unless some relief is given the chances are that the patient will succumb to the disease inside a few weeks or months at least. I recall a case of this kind in an old lady in whom there were slight attacks of vertigo and mental confusion followed by melancholy of a mild type for a few weeks, then delusional insanity which lasted for several weeks, when she was sent to an asylum, where she died three or four days after being admitted. This patient had interstitial nephritis with disease of the heart and the usual circulatory disturbances, urine low specific gravity with some albumin and tube casts. There was no hereditary predisposition in this case. I therefore believe it to have been a case of uraemic insanity. It was probably a mistake to have sent this patient to an asylum. If the case be one of hereditary insanity occurring early in chronic Bright's disease, it should be sent to an asylum where great relief may be given. Perhaps the greatest importance of this entire subject is from a medico-legal standpoint. The civil issues involved are numerous, and are liable to attract the attention of the courts. The questions involved are criminal responsibility, personal liberty, testamentary capacity and such questions as the power to manage property, make deeds, sign promissory notes, etc. A case of this kind was before the court in Robinson, Ill., a few years ago and a similar one in Carbondale, the following year. At that time the mental disturbances in Bright's disease had been studied but little by the general practitioner, and he hardly regarded them as destroyers of testamentary capacity or criminal responsibility.

## CERTAIN POINTS REGARDING THE CLINICAL USE OF THE VARIOUS HEART STIMULANTS.\*

BY ARTHUR R. EDWARDS, M. D., CHICAGO.

The subject of heart stimulants and the indications for their use is indeed an old and worn topic, yet there are many gaps in our experimental studies, many mooted points in our clinical indications and a number of discrepancies between the laboratory results and results at the bedside, as for example, in the indications and *modus operandi* of alcohol. While in no way underestimating the results of laboratory experience, we must insist upon the importance of bedside observation.

The ammonia preparations are of the greatest clinical importance and their chief sphere of action is upon the circulation, although in therapeutic doses, they operate as direct and powerful centric stimulants to the respiratory center and directly or indirectly to the nervous system. Ammonia acts in a transitory manner upon the circulation, yet, although fugitive in its effects, it stimulates the heart muscle, increases the frequency of the pulse and constricts the peripheral vaso-motor system, thereby contributing to raise arterial tension. Its effects are rapidly observed in local flushing, subjective warmth, tension in the temples, a sense of exhilaration and increase in the urine, sweat, and mucus secretion. Its prime indication is sudden and functional cardiac adynamia such as is observed, for example, at the crisis of pneumonia. It is a local irritant to the skin and subcutaneous tissues as well as to the respiratory and alimentary mucosae, wherein lie its therapeutic value and its clinical drawbacks. Its irritant or stimulant properties upon the nose, mouth and upper respiratory tubes explains the sudden reflex stimulation of the respiratory and circulatory centres which follows its appli-

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

cation on cotton, etc., to the nose, its use as smelling salts and the centripetal stimulation traveling from the throat, oesophagus and stomach to the brain, long before the drug is absorbed. Untoward action is frequently observed in gastric, intestinal, renal and bronchial irritation in over doses and also in undue irritation or necrosis following subcutaneous administration. Its corrosiveness and fugitive action are both very relative contraindications, obviated by administration of small and frequent doses. In pneumonia *e. g.*, it stimulates the secretion of mucus.

In the use of alcohol the chief interest centers on its action upon the circulation. From years back alcohol has been held as a heart stimulant although notable objections have been raised to this statement. The frequency of the heart's action is increased but it is known beyond all doubt that the drug acts as a vaso-dilator. No pharmacologist now holds that alcohol stimulates the heart, as to digitalis, strychnia or camphor. Some clinicians use alcohol for weakened circulation in typhoid, pneumonia or sepsis and see good results. Other practitioners refuse to employ it because it is a narcotic to the nervous system and to the vital respiratory, circulatory and vasomotor centres in the lower brain. Some of the latter class refuse to use it from prejudice and others of them fall back upon the laboratory results which go to prove the absence of cardiac stimulation after use of alcohol. None can, however, gainsay that alcohol has some good effects. In acute collapse, especially of the psychical variety, it is of benefit. In febrile affections with chills, it is of value, since it relaxes the arterioles and in tub baths as in typhoid it is most useful, since in relaxing the cutaneous vessels it brings greater quantities of blood to the skin to be cooled. How can alcohol be of benefit, when we must abandon the formerly entertained idea that it stimulates the heart? It has seemed to me that alcohol may stimulate the heart by reflex action upon the brain by irritating the throat and stomach mucosa.

Again I cannot abandon the idea that al-

cohol is of value in sepsis, in whatever unknown way it may work good. Possibly it may avail by neutralizing the septic substances or counteracting the vessel spasm so often observed in septicopyaemia, since relief of undue peripheral resistance is an indirect cardiac stimulant. Direct cardiac stimulation by alcohol *per se* is out of the question, save in those preparations which as champagne contain other ingredients.

Vasomotor paralysis and collapse result from the accumulation of blood in the abdominal vessels. Thus Von Basch observed pallor of the retinal vessels follow section of the splanchnic nerve. Gottlieb prefers caffeine and camphor to combat this vasoparesis to strychnine whose dosage necessary to constrict the vessels he holds is too nearly the dose likely to produce convulsions. While this is the opinion of a distinguished pharmacologist, it will not receive general support from clinicians and practitioners.

In the collapse of acute toxæmia or other conditions, the vaso-dilatation is general but particularly concerns the deep abdominal vessels. Strychnia is here indicated not only because of its general effects, but because of its vaso-constricting powers on the deep vessels, since it is known that the drug tones the abdominal vessels while the vascular tonus in the skin and brain is not increased, thereby flushing the brain vessels and stimulating the bulbar vasomotor and other vital centres. Cold has an analogous effect on the splanchnic nerve which is the abdominal pneumogastric.

It is my personal belief that opium and morphine are not sufficiently recognized as vascular and cardiac tonics. Many clinicians withhold these remedies in pneumonia and typhoid, for example, even when maniacal outbursts and active delirium would demand the drug, because it seems, of theoretical objections. One constantly encounters objections to the use of morphine for pain, restlessness or delirium, because the drug depresses respiration and ill effects upon the circulation are feared. In its free use pneumonia and other acute toxæmias, the drug seems to decrease the irritability of the respiratory centres, thereby less-



ening cough and dyspnoea with the attendant headache and insomnia and invariably acts as a strong cardio-vascular tonic. Its effects on diseased kidneys are not to be feared with ordinary care in administration. Morphine will of itself help to sustain life for days and in several most critical cases where I have watched its effects for consecutive hours, its hypodermic use will strengthen and regulate respiration even when Cheyne-Stokes respiration is marked and, where the heart weakens, its force will often be renewed. It is a most valuable adjunct to the true cardio-vascular stimulants, either those which have continued action as strychnia and digitalis, or those whose action is more fugitive as camphor, ammonia or caffeine.

The prototype of the chemical cardio-vascular stimulants is now as always, digitalis. In therapeutic doses, its action is as follows:

(a) Digitalis increases the tonus of the heart muscles, thereby averting or remedying dilatation. It must be remembered that the main action of the drug is on the heart muscle and that successful therapeutic response depends almost solely upon the condition of the myocardium and its intrinsic ganglia. If great and hopeless disease of the myocardium exist, its last appeal to the heart muscle is indeed vain. Dilatation is the essential indication, according to many clinicians, for the use of digitalis, and is signalized by the usual signs, as a weak first tone, etc.

(b) The second indication is functional dissociation. The drug co-ordinates the cardiac activity and therefore is used for irregular cardiac action. It is a cardiac tonic, possibly acting through the trophic branches of the vagus. According to the views of Oppenichowsky, it is valuable when there is over-activity of the left ventricle and reduced activity of the right ventricle, which combination burdens the pulmonary and venous circulation. The ventricles are claimed to have separate innervation.

(c) Where rapid heart action is observed. Digitalis operates best in stasis, when the pulse is relatively fast. The cardiac fre-

quency is decreased. The systole becomes strong and it is estimated that the left ventricle, under the influence of the drug, contracts with three to four times the normal strength.

If the drug is pushed beyond the therapeutic limit, the action of the drug is accentuated, and the heart contracts not wholly at one time but parts of the ventricle successively. The heart muscle is squeezed dry of blood and the heart's action is arrested in systolic spasm. This slowing and strengthening of the heart's action renders more complete the systolic functions of the chambers of the heart. More blood is forced out into both the venous pulmonary circuit and into the arterial system of the other side; thus both the general and pulmonary areas are relieved. The lengthened diastole permits of the freer inflow of the blood from the venous circulation and from the pulmonary area.

(d) The intrinsic cardiac circulation is improved.

(e) Arterial pressure is elevated in moderate doses, due to (1) increase of the working power of the heart, and (2) to the contraction of the arterioles from the centric stimulation and from local action.

The question of arterial tension often aids us in considering the indications for the drug. A certain amount of peripheral resistance, i. e., tone on the part of the arteries, is necessary to normal heart action. It has been noticed in many instances that digitalis may lower the arterial pressure, although, indeed, this is not the rule. This condition is paradoxical and may possibly be explained by lessening the dyspnoea which as is well known, results in constriction of the peripheral vessels.

Toxic doses are well recognized as reducing arterial pressure. It should, then, be remembered that in cardiac dyspnoea, resulting from nephritis and arteriosclerosis, digitalis is not necessarily contraindicated. It may, given alone, lower arterial pressure by relieving dyspnoea or it may be indicated with some other remedy which will "unlock" the peripheral arteries, i. e., relieve peripheral vessel spasm.

We will not enter into the indications and mode of action of digitalis in the individual valvular lesions of the heart.

The contraindications to the use of digitalis are:

- (1) Balanced compensation.
- (2) If rest in bed, active purgation, etc., have not been previously attempted.
- (3) Adequate hypertrophy.
- (4) Where danger exists in the direction of vessel rupture as in very marked atheroma, aneurysm, etc., recalling the fact that brain hemorrhage may follow the incautious use of digitalis, strychnia and other drugs which result in over-action of the heart and vasomotor spasm.
- (5) Marked fatty degeneration of the heart. This does not apply to fatty degeneration *in toto*, but merely to extreme grades of the lesion, since we know that fatty degeneration is often merely an evidence of malnutrition, possibly of stasis and may be helped by digitalis.
- (6) When the vessels are contracted strongly, we obviate angiospasm by combining the drug with strophanthus, or nitroglycerine, which especially in aged hearts is recommended by Balfour. To use his expression, nitroglycerine "unlocks" the peripheral vessels.

When digitalis is given for a long period, it is our personal preference to combine it with the iodides.

Regarding the cumulative action of the drug, which is denied by many but nevertheless must be admitted, the drug should be given with intermissions, although it may be kept up in small doses for months or even years. Great care must be exercised in ambulatory dispensary or office patients. Care must be exercised when the drug has been used in dropsy, since sudden absorption of the fluid may result in toxic symptoms precisely as uraemia may follow disappearance of oedema. Again toxic symptoms may intervene when the drug has been given during fever, upon whose cessation or crisis toxic symptoms frequently develop.

Since the article is limited to the general considerations, we will not especially enter into the different forms in which the drug

may be used. Practically all of the preparations of digitalis have much the same action. Here we merely note that in some instances where digitalis has failed us, both in the form of fluid extract, tincture and infusion, digitoxin has proved efficient.

Unverricht has exploited the advantages of digitoxin, while Naunyn with others of his school. Porter, etc., have seemingly demonstrated its inferior value or inefficiency. In a number of cases of acute cardiac insufficiency, in muscular weakness, due to acute myocarditis in rheumatism, exophthalmic goitre, in valvular lesions, etc., we have seen digitoxin produce the most striking results, when other preparations have failed. In these cases the previous administration of the drug and the natural regression of the disease have been carefully excluded. In these instances in which the drug has been used successfully in doses of 1/400 grain, given two to three times daily, the pulse rate has been greatly reduced, as from 120 or 140 to 40, 60 or 80, the power of the heart is increased, diuresis re-established, co-ordination of the heart's activity effected and all of the results accomplished usually following the administration of digitalis as a drug and as a whole. While not claiming for digitoxin any invariable advantages which digitalis has not, still there seem to be selected instances where after the failure of other preparations, digitoxin will not merely stimulate the heart but raise arterial pressure.

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#### LYMPHADENITIS AND ABSCESES OF THE LIVER AS COMPLICATIONS OF APPENDICITIS.\*

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BY M. L. HARRIS, M. D., CHICAGO.  
Professor of Surgery, Chicago Polyclinic.

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So much has been written during the past few years concerning the pathologic changes and the clinical course of the usual case of appendicitis, that there is little, if anything, new to be learned by further repetition in this direction. As is usual, a knowledge of the more common forms is gained first, while the rare forms and unusual complications

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\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

are only recognized as knowledge and experience broaden. It is the intention in this communication to briefly mention some of the unusual complications of appendicitis, which owing to their rarity are often misinterpreted, and as a result fail to receive the most appropriate treatment.

The first of these complications is lymphadenitis. As is well known, the appendix contains a large amount of adenoid tissue and is rich in lymph vessels, which are tributary to a group of lymph glands located in the mesocolon near the ileocecal junction. A lymphangitis and lymphadenitis occur to some degree in practically all cases of acute appendicitis, but it is not to this condition to which attention is directed. The condition here referred to is an inflammation of the above mentioned group of lymph glands attended by such a degree of swelling as to lead to the formation of a distinct enlargement or tumor in this region. The infection giving rise to this inflammation commonly has its origin in the appendix. Small denudations or abrasions and even ulceration of the mucosa are not uncommon in the appendix, and in the absence, too, of distinct symptoms of acute appendicitis. Such an abrasion or ulceration may form the infection atrium through which microbes may pass to the nearest lymph glands, where they are arrested and give rise to inflammation and enlargement in the same manner that the glands of the neck may be inflamed and enlarged by an infection taking place through a decayed tooth or inflamed tonsil. In either case, during the height of the lymphadenitis the infection atrium may show no active changes whatever. The author has seen within a short time two cases of marked enlargement of the ileocecal group of lymph glands due to infection through the appendix.

The first of these was a young woman who presented the usual symptoms of an acute appendicitis, with a large, firm and irregular mass in the right lower quadrant of the abdomen, which was supposed to be formed by the usual exudate about the appendix with suppuration. The case was operated on, and on opening the abdomen the appendix was found acutely inflamed

and imbedded in a small amount of recent exudate. The large mass which had been so distinctly felt lay to the inner side of the cecum and colon, and was composed entirely of enlarged and hard lymph glands. Behind the colon was an abscess, probably due to the infection of this space by a broken down suppurating lymph gland. The abscess was opened and packed in the usual way, the appendix removed, and the patient recovered, but convalescence was very slow, and it was several weeks before the mass entirely disappeared.

The second case was that of a young woman 30 years of age, who was taken ill with pain in the region of the appendix, with fever, vomiting, distention of the abdomen with muscular rigidity and tenderness. A mass about the size of a large hen egg, which was exquisitely sensitive, was easily felt in the lower right quadrant of the abdomen. Acute appendicitis was diagnosed, and an operation done at once. The mass was found to be a bunch of enlarged lymph-glands. The appendix was free in the abdominal cavity and without apparent changes on the outside. It was believed to be the source of infection, however, and was removed and the abdomen closed. The patient recovered and the mass slowly disappeared, but she complained of pain and soreness in that side for many weeks thereafter. The interior of the appendix showed a number of small hemorrhages in the mucosa, with denudations in places of the epithelium.

In these two cases the mass was not recognized as due to enlarged lymphglands before the operation.

The enlargement of the lymphglands in these cases usually disappears after, the removal of the appendix, the source of the infection; but that such does not always follow is shown by an interesting case reported by Brewer (*Annals of Surg.* 1898, xxviii, 366) in which a retrocolonic abscess formed, due to a suppurating lymphgland, several weeks after the removal of the appendix, and after the patient was up and around apparently recovered.

The second complication to which attention is briefly directed is metastatic suppurative infection of the liver. The transmis-



sion of the infection in these cases takes place in the following manner: A phlebo-thrombosis occurs in the efferent appendicular vessels, which are radicles of the portal system. From this point a pyle-phlebitis of the vena portae develops with subsequent infection of the liver. Or, minute infective emboli may separate from the primary thrombus, and lodging in the liver give rise to abscesses. Again the infection may take place through the lymphatics, in which case the microbes enter the general circulation and are eliminated by the liver with the production of a suppurative cholangitis with or without small multiple disseminated abscesses throughout the liver.

The author has recently met with two such cases. The first case occurred in a young man about 30 years of age, from whom the appendix had been removed on the third day of an acute attack of recurrent appendicitis. Suppuration was present, and the cavity was packed and drained with gauze in the usual manner. For the first two weeks after the operation the progress of the case was very favorable, recovery seemed assured and no further anxiety was felt. From this time on a slight irregular temperature appeared, for which repeated examinations failed to reveal sufficient cause. The daily excursions of temperature became more pronounced, the patient emaciated and a small amount of albumen appeared in the urine. The hepatic area became slightly enlarged and somewhat tender, and the aspirator was used in search for pus. During one of these punctures a few drops of pus were withdrawn, and as the patient's condition was becoming progressively worse, it was decided to explore the entire region more thoroughly by operation. Plastic exudate fixed the liver to the diaphragm and parietes. The same kind of adhesions were found between the under surface of the liver and the colon and about the gall ducts. No pus cavities were found either about the intestines or in the liver substance. No improvement followed, and the patient died about eight weeks after the first operation for the removal of the appendix. Cause of death, suppurative Chol-

angitis with small multiple foci of pus disseminated throughout the liver.

The second case was that of a young man about 37 years of age, who developed rather rapidly symptoms of an acute septicemia. After about a week of his illness he began having chills, usually one a day at an irregular time, with a temperature of 104 to 105, which usually dropped to between 99 and 100 in the morning. A systolic cardiac murmur could be distinctly heard, but whether it was present before this illness was not known. He complained of no local symptoms or distress of any kind, except an occasional vomiting of his food, and although repeated consultations were held over the case, the local point of infection could not be determined. There was no tenderness anywhere about the abdomen. The hepatic area of dulness was perhaps slightly enlarged. The spleen was distinctly enlarged and its edge could be felt at the costal margin, but it was not sensitive. After about three weeks a small mass about the size of a hickory nut was discovered in the region of the appendix. It was movable and not especially tender and was due to enlarged lymph glands. There was no distension of the abdomen, rigidity of the muscles nor disturbance of the bowels. Urine examination, negative. Blood examination showed 10,000 leucocytes. No plasmodia. Widal, negative. About five weeks after the beginning of his illness he was brought to the hospital and came under my care. He was quite emaciated and his condition very serious. It was decided to open the abdomen and explore. The incision was made over the appendix. This was found extending upward and inward through and above the mesentery of the lower end of the ileum. It was enlarged and its walls thickened and inflamed. Owing to its location, through the mesentery, much difficulty was experienced in removing it, and doing so its walls, which were very fragile, were ruptured, giving exit to a few ces. of pus. Some of the veins of the mesentery were lacerated, giving rise to very profuse hemorrhage, controlled after considerable time by tamponing. Nothing further was discovered in this region, and as his condi-

tion was quite serious, the operation was terminated. For a few days he appeared to be better. The chills ceased entirely and the temperature did not go so high. It did not last, however, and he died on the eighth day after the operation. At the autopsy the following conditions were found:

No adhesions whatever had taken place about the packing left in the wound. A small ulcer in the cecum had perforated the wall of the bowel and communicated with a small retroperitoneal abscess about which a lymphangitis was marked. A small abscess near the head of the pancreas between it and the duodenum. Several small foci of pus between the omentum and loops of small intestines. Gall stones with pus in the gall bladder and gall ducts. Numerous small abscesses disseminated throughout the liver. The cardiac murmur was due to an old valvular lesion.

**Anatomic Diagnosis:** Suppurative Endo-appendicitis, perforating ulcer of the cecum, retroperitoneal abscess with lymphangitis. Suppurative cholangitis with multiple abscesses of the liver.

This case illustrates the fact that an infection may take place through the appendix with the production of metastatic abscesses, which may prove fatal, while the local symptoms may be so slight that the point of infection may escape detection for a long time. A number of similar cases which need not be reproduced here may be found in the literature.

(Munro. *Therap. Gaz.* 1901.) Morris' notes on appendicitis, 1899. (Hildebrandt's *Jahrenbericht* 1901.) Deaver treatise on appendicitis, second edition, 1900.

Attention has not been directed sufficiently to infection of the bile tracts and liver in connection with appendicitis, and it seems quite probable that in quite a percentage of the cases that die either after an operation or without one, metastatic infections of the liver would be found. In 108 cases of abscess of the liver, Langenbuch (Deutsch. *Chir. Buch* 45c, 1 halfte, S. 233) found eight of them due to affection of the cecum or appendix. Einhorn found in 100 cases of appendicitis which came to autopsy four cases of infection of the portal vein and liver.

Langheld in 112 cases, pylephlebitis four times and liver abscess two times. Fitz in 257 cases, pylephlebitis and liver infection 11 times. (Nothnagel, *Pathol. Bd.* xviii, S. 325.)

These statistics show the necessity of directing the attention to the liver in all cases of appendicitis that present evidence of obscure complications, also on the other hand, in cases of evident infections of the liver or bile tracts to bear in mind the appendix as the possible source of the infection.

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### APPENDICITIS, WHEN SHALL WE OPERATE.\*

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BY H. C. MITCHELL, M. D., CARBONDALE.

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In writing a paper on this subject, I have not attempted to give anything new, because every phase has been thoroughly covered by former writers. In fact, if all that has been written could be compiled in one volume, it would require several life times to read it all.

Notwithstanding so much has been written, we are still groping in the dark as to the proper time to operate in all stages of this affection. The opinions of different writers and operators are almost as different as the shells on the sea shore. In attempting to write a paper on this subject, with my limited experience, I am not unaware of the fact that I am exploding a bomb, and that I shall probably be standing over its crater.

But if I succeed in throwing one ray of light as to the proper time to operate, this paper will not have been written in vain. I have been of the opinion for years, that many valuable lives are sacrificed annually, because of the present practice of the profession, in operating on these cases in all stages of the disease. One operator will tell you with all the gusto imaginable, that all the conservative method, is to operate in all stages of the disease. Another will tell you with quite as much emphasis, that all the conservative method, of operating in appendicitis, after the infective process has passed beyond the confines of the appendix,

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\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

is that of proerastination by withholding food, stomach lavage, etc., until the acute stage has passed.

Who are we to believe? These questions will only be settled by years of experience, and comparison of notes, as all other operations of so grave a character have been done in the past.

Taking into consideration the anatomical boundaries of the appendix, it is admirably situated for throwing a natural wall around itself when infected, baring the danger of infection by intestinal peristalsis in the median line.

Surrounded as it is by fixed tissues in nearly every direction; above we find the lower end of the cecum, and the cecal end of the illium, to the right, and in front the parietal peritoneum, behind lies the peritoneum covering the iliatus muscle and in the median line we find loops of intestine. The omentum in the majority of cases extends quite a distance below the appendix.

It must be admitted by all, that the majority of cases of appendicitis that die, do as a result of general peritonitis. It is equally true that the infection is spread by means of intestinal peristalsis to the general peritoneal cavity. This being the case, we believe every measure possible should be used to prevent intestinal peristalsis. The best methods of accomplishing this, we believe, are described by Dr. A. J. Ochsner, of Chicago, in his able paper on "The Cause of Diffuse Peritonitis, Complicating Appendicitis and Its Prevention." The doctor states, that practically no peristalsis will occur unless food or cathartics are introduced into the stomach, and recommends that gastric lavage be performed until all food substances be removed from the stomach and the patient be nourished entirely by the lower bowel.

By emptying the stomach and small intestines of their contents, you not only prevent peristalsis, but prevent the formation of noxious gases and their pressure against the inflamed tissues. If this form of treatment is begun early in the case, it is of incalculable benefit in preventing general peritoneal infection. The profession is a unit in operating on all cases of appendici-

titis, if seen in the first twenty-four to thirty-six hours, while the infection is still confined to the appendix, because it can then be done safely, without almost no mortality. The great trouble is, however, the surgeon rarely ever sees the patient until after that time has passed. It is our contention, that it is in the stage of the disease where the infection has passed beyond the confines of the appendix, that the great mortality from operation occurs. In the stage just described you will have in all probability, either a gangrenous, or rupture of the appendix, and as a consequence, either a localized or general peritonitis. It is in this stage of the disease that gastric lavage is practiced with the greatest success, in preventing intestinal peristalsis, and the consequent spread of infection to the general cavity.

An operation that gives as low mortality as one-half to three per cent, as we get in appendicitis when the infection is still confined to the appendix, is certainly warranted, but when it has passed beyond the confines of the appendix, there are numerous questions to be considered. It seems to me that the rational method of treatment under such circumstances, would be to institute a line of treatment that would confine the infectious material to a localized area. To accomplish this, it is necessary to put all the tissues around the infected area at perfect rest. The lesson has long ago been learned, by abdominal surgeons, that is hard to overestimate the value of rest to an inflamed peritoneum.

I know that it has generally been considered that there is great danger of rupture of a circumscribed abscess, but such is not the case, except it ruptures into the bowel or bladder. The experience of our best operators has been, that such a thing rarely ever occurs. It is nearly certain, that if your case is one of the localized infection, and you withhold all food from the stomach, that your patient will be better in from twenty-four to forty-eight hours, and that they will pass rapidly to convalescence, and in a few days or weeks can undergo an operation with but little risk of infection. Very many times in the past few years have I



seen patients with all the characteristic symptoms of appendicitis, viz., pain, temperature, tenderness, vomiting, rigidity and induration in the right side, at or near McBurney's point, but with prompt lavage of the stomach and washing out the colon with a copious enema, and then keeping the patient perfectly at rest, so as to prevent any peristalsis, I have seen them nearly every one recover. On the other hand, I have seen patients with identically the same train of symptoms operated on, with a mortality of at least thirty-three per cent.

I want to go on record, as saying, that it is my opinion, that patients suffering with appendicitis in all walks, and conditions of life, and taking into consideration the operators into whose hands these patients will fall, more will recover without than with an operation, after the infectious material has passed beyond the appendix, except there be general peritonitis, in which event there is only a choice between operation and death, with usually death as the conclusion. When you take into consideration the class of patients I have just described, with localized infection outside of the appendix, and the many complications that may, and do so often arise, as a result of operations—such as general peritoneal infection, drainage, post-operative ventral, hernias, breaking up of adhesions, and tearing holes into the intestines, intestinal fistula, that a greater percentage of cases will recover without than with an operation, if the cases are treated after the pain I have described.

Dr. J. B. Murphy says that from five to eighteen per cent of all cases of appendicitis not subjected to operative treatment will die. Other operators place the mortality list at three to sixteen per cent. Dr. Murphy also states that there is a mortality of twenty per cent in the cases of perforate or gangrenous cases operated on, while Dr. Ochsner claims by treating this class of cases by rest, lavage, etc., until the acute stage has passed, he has reduced the mortality to five per cent, and further says that he is sure that if the treatment had been instituted at the beginning of the attack, that the mortality could have been reduced to

two and a half per cent. Of three hundred and sixty-eight cases operated on by Dr. Ochsner that had passed the acute attack or were suffering with a recurrent attack, only one proved fatal, or less than one-third per cent mortality, which speaks volumes for the waiting method. In conclusion I desire to say, 1st, that I think that all cases of appendicitis should be operated on if possible while the infection is confined to the appendix. 2d, that practically all cases where the infection has passed beyond the appendix should be allowed to take their chances with treatment by quiet, lavage, enema, and rectal feeding, until the acute stage has passed before operation, unless the case be one of general infection, when the sooner an operation is done the better, unless the case be one that has passed into a stage of collapse that renders it hopeless. I verily believe that when we have reached a point in our professional career, when our zeal for conservatism surpasses that for operation, we will cure a greater per cent of our patients than we are now doing.

#### TRAUMATIC INJURIES TO LIVER; REPORT OF A CASE.\*

BY J. L. WIGGINS, M. D., E. ST. LOUIS.

The number of reported cases of laceration of the liver has increased of late years, as the field of abdominal surgery has been enlarged.

Its diagnosis; divested of direct history of injury does not differ materially from injury to any of the abdominal viscera, being that of shock and hemorrhage. This is of slight importance in locating lesion, as hemorrhage follows laceration of any of the contained organs, and shock, which indicates merely the abolition of the controlling influences exercised by the nervous system over the vital organic functions of the body, may be produced with equal severity, by mental as well as physical conditions.

In examining reported cases one is impressed with the number in which it is further noted that vomiting of greenish bile ensued, this being frequently tinged

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

with blood; yet no logical explanation is advanced as to the reason why blood should be in evidence in the vomit of those suffering from hepatic injuries, except the suggestion, that possibly there was an injury to the stomach which had escaped observation.

In this case, not only can we exclude the stomach from any injury, but also every other organ in the abdomen, as all were closely examined previous to the location of the wound.

It occurs to us that we may well give some attention to this clinical symptom as an aid in locating more definitely obscure lesions, especially in non-penetrating wounds. Usually the anterior surface of the liver is involved, this on account of its exposed position, and the fact that in many instances, a fracture of the ribs the result of the violence, precedes injury to the liver.

Whenever the sharp point of a fractured rib penetrates the liver substance shock and hemorrhage follow immediately. Under these conditions blood escapes without restraint into the free abdominal cavity. If however, there be no wound of this nature, the clinical symptoms are considerably masked, and the patient need not present marked symptoms of shock, although indications of abdominal injury may exist, from a period ranging from a few hours to several days, we may then have a sudden collapse, or the formation of abscess in the hepatic substance. This has been the observation without any clear explanation.

We would call attention to a few anatomical points for a clear understanding as to how delayed shock, abscesses, bloody vomit or stools may ensue. The surface of the liver is covered by a strong fibrous capsule which under the name of Glisson's capsule, accompanies the portal vessels into the liver; all surface portions are further reinforced by a layer of peritoneum, except at ligamentous reflections, the fissure of the gall bladder and the portal fissure. The liver substance is a soft solid, friable and composed of lobules each of which represents an independent atom of the whole, the essential element being the secreting cell; the grooved surface of contiguous cells form-

ing the beginning of the bile duct radicles, which pour their secretion into a common drain, which empties into the second portion of the duodenum, with the duct of the pancreas; about four inches from the pylorus. The anterior liver surface being in contact with the thoracic cage, may by impact, cause a separation of the friable tissue beneath, without causing a laceration of the serous or fibrous coats. Under these conditions we would have a limited shock, referable to the sympathetic nerves, but blood and bile extravasation would be limited by the coverings and the further support of chondrocostal apposition. The fluid under these conditions would follow the law of projectiles, insinuating itself along the course of the least resistance. If adhesions following inflammatory action ensued, between the hepatic and diaphragmatic peritoneum, up to a certain point the least resistance would be directed toward the center of the organ, the sides of the fissure being separated by the accumulation, to their utmost limit, then reversed along the point of adhesion, on outer surface until rupture ensued, followed by pouring of contents into abdomen. Before this takes place, however, we would find according to depth of fissure, a greater or less quantity of blood forced through the hepatic ducts into the duodenum, with a resulting bloody vomit, and if excessive, bloody stool. The case presenting itself to my service was a Polander; aet 31; height 5 ft. 8½ in.; weight 170 lbs.; very muscular. Was seen by assistant company physician March 27th, 1901, at 12:45 A. M.

History: While manipulating large shears at rolling mill was struck by a piece of boiler in abdomen. There was but slight shock; patient conscious; he complained of severe pain in left hypochondriac region. The following morning pain was accentuated, tympanites ensued and intestinal paresis developed. Tem. 101; pulse 106; and of fair volume. Solution of Mag. Sulph. given followed by high enema, resulting in free bowel movement.

Second day. A. M. Tem. 101; P. 96. P. M. Tem. 100.4; P. 88. At this time he

was free from pain; bowels having moved four times during day.

Third day. A. M. Tem. 98.8; P. 88. P. M. Tem. 98.8; P. 70. Fluid nourishment was given without any bad results. Bowels open. The symptoms at this time as shown by temperature, pulse, and general condition indicated no serious lesion. There was no marked pain at any point upon pressure, and the dullness over hepatic area extended but little below the normal line.

The case was considered past the point where it required any special attention. This condition was continued until 10 A. M. of fourth day, when on rising, patient was seized with sharp pain in right side, followed by syncope, and all indications of shock; temperature subnormal; pulse rapid.

The nature of the injury at this time was not suspected. Vomiting of bloody bile ensued, and also large bloody stool. This condition suggested to my mind the bursting of a haematoma into the abdomen which also connected directly with the intestinal canal, and the fact that the blood was freely mixed with the vomit suggested a point close to the pylorus. The abdomen was opened by free incision along median line and found to contain from six to eight litres of dark venous blood.

An examination of upper surface of right lobe of liver, disclosed a stellate rupture two and one-half inches from anterior margin, situated directly over fissure of gall bladder; its diverging points being contained in the right lobe, while the spur was opposite quadrate lobe. The wound was three inches long, the lacerated tissue being in close apposition. There was slight hemorrhage except at the point of convergence, where there existed a loss of hepatic substance about one-fourth by one-fourth inches.

The gall bladder was greatly distended with about 4 oz of dark greenish brown fluid, evidently of the same character as that within the free abdominal cavity.

The wound was sutured with No. 2 catgut, abdomen cleansed and closed without drainage. At the time of, and following the operation, patient was moribund.

Intravenous injection  $\text{O}_2$  of normal salt solution was given and repeated every twelve

hours. His pulse ranged from 80 to 130 and his temperature from 98.6 to 103. On the 12th day after operation, symptoms of shock again ensued with considerable pain in hepatic region. During this period he had much trouble with bowels; they being loose tympanitic, with waxy colored stools and occasional passage of blood clots. On the 22d day, dullness was discovered over liver, indicating reformation of the haematoma. I aspirated withdrawing about three ounces of blood and bile. On the following day I resected three inches of the seventh and eighth ribs, wiping out the cavity and introducing loose gauze drainage.

His temperature, which was at this time 103, fell to 100.6. Two days later there was a free discharge of bile saturating dressings and bed. The amount secreted daily being from two to three pints. His temperature ranged from 98 to 101, and the secretions of bile gradually decreased until fistulous wound closed July 17th. A very conservative estimate of quantity of bile secreted in the fifty-three days in which the wound was open, would be fourteen gallons.

The drain of biliary secretion caused great emaciation. All nourishment was rejected nutrient enemata expelled.

Bowels did not move except as the result of high stimulating enemata; stools were light color and generally of fetid odor.

The patient was discharged August 10th, 132 days from time of first operation. He resumed his work and so far as I am able to learn has since suffered no inconvenience as the result of the injury.

#### CONCLUSION.

That delayed bloody vomit or stool in obscure abdominal injuries is indicative of rupture of hepatic substance without laceration of its fibrous and serous coverings.

That no method of suturing can be entirely satisfactory—

1st. Because if laceration is superficial it is not required.

2d. If laceration is deep the dead space cannot be obliterated, as a consequence there is an accumulation of arterial and venous blood mixed with the bile from the vascular organ which may become infected forming an abscess, or if accumulation is exes-



sive, break line of suture and tear protective adhesions.

3d. That suture material to be of any service must be large to control hemorrhage it must exert pressure. In the first instance many lobules must be destroyed, and interference with venous and arterial branches and secreting radicles—in the second—a tight drawn suture would cut through friable structure or cause tissue necrosis.

4th. All sealing material with the possible exception of the actual cautery are not plausible in theory or warranted by results.

That the best results accrue from drainage by most direct route and isolating drainage structure.

5th. That immediate operation irrespective of degree of shock is the only rational method of treatment and the only one based upon reported cases which has yielded results.

#### Discussion on the Papers of Drs. Harris, Wiggins and Mitchell.

Arthur Dean Bevan, of Chicago: I want to say a word or two in regard to Dr. Harris' very instructive paper on **Lymphadenitis**. I know that in my own work I have seen a number of cases, as an example of which I shall mention one, bringing out the point of the involvement of the lymphatic glands in cases of appendicitis. A boy, about thirteen years of age, with a distinct, definite history of acute appendicitis and recurrent attacks, came to me, and on examination I found a hard mass in the region of the appendix, and made the diagnosis of the mass being an inflamed appendix. On operating I found a small appendix, bound down with adhesions, and the mass which I found was not the appendix, but a mass of glands in the cecum. Since that time I have noticed in a number of cases quite distinct enlargement of the lymphatic glands in the meso-cecum which are mistaken sometimes for an inflamed appendix. They are especially important from the standpoint that many of them are probably tubercular. Of course, this brings up the great subject of ileo-cecal tuberculosis.

One point in regard to the paper of Dr. Mitchell, and it is this: We have discussed the subject of appendicitis in every medical society for the last ten years. There are usually two groups of men, one the radical group, who operate on every case of appendicitis as soon as the diagnosis is made; the other group resorting to conservative treatment in almost all cases. What are the facts? No man on earth can lay down any iron clad rules which will govern any surgeon, when he is brought face to face with a case, and if you analyze the facts you must admit that the greatest triumph of modern surgery is the American

treatment of appendicitis by surgical methods, which was the result of the work of Willard Parker, of Sands, and of McBurney, and their followers. No chapter in modern surgery will compare in brilliancy of results and in the amount of good accomplished with this chapter of the American treatment of appendicitis by surgical means, and we are slowly convincing the rest of the world of that fact. We have convinced Frenchmen, and some of them have gone too far, and have taken the position that every case of appendicitis should be operated on, just as a case of strangulated hernia. This is going to the extreme. We are gradually converting English and German surgeons on the continent to our way of thinking. The Germans still cling to the internal treatment of appendicitis, which has been called the Ochsner treatment here. It is the treatment of Solly and Korte, and it has but one single idea, that the patient should have peristalsis reduced to a minimum, with nothing in the stomach, no food by the stomach, but a rectal feeding, opium to control pain, thereby reducing peristalsis to a minimum. That is scientific treatment, but it is not to be compared for a moment with a modern surgical treatment of this disease. The treatment of appendicitis is distinctly surgical. This other method of treatment is of value only under conditions when the modern surgical treatment cannot be employed.

Everett J. Brown, of Decatur: Mr. President. In regard to appendicitis, I wish to say a word or two from the standpoint of a general practitioner, and that is, I do not regard appendicitis as a medical disease. I do not believe that there is such a thing as medical treatment of this disease. There is no doubt but what this most treacherous disease will often be recovered from by so-called medical treatment. I could mention at least two dozen patients whom I have treated medically during my professional career, and who have recovered; at the same time, I regard it as unsafe treatment. The essayist stated that as soon as the inflammation had passed the appendix, we should operate. I will defy any man to diagnose when that time occurs. It is impossible to tell when the inflammation is in the appendix, and produces enough trouble to require an operation according to the condition he states. The consensus of opinion among surgeons and internists is that appendicitis cases that are getting worse, with the pulse increasing, more attention should be given to the pulse than to the temperature. If, at the end of twenty-four hours, the pulse shows a tendency to improve, and pain is less, it is safe to use the Ochsner treatment, that is, abstinence from all food, and lavage of the stomach, and absolute rest until the acute symptoms have disappeared, and then make an interval operation, which, in the hands of good operators, is practically free from mortality. It has been my practice, when called to see a case on the fourth or fifth day, in consultation, to hold the case until later, and do an interval operation, because we all realize the fact that the fourth, fifth and sixth days are the fatal days of appendicitis, while after

symptoms have disappeared, it is a safe operation.

**W. F. Grinstead**, of Cairo: This subject of appendicitis has given me as much worry as any other topic I have come in contact with in my work. We often find ourselves in the presence of a disease which we recognize to be a dangerous one, and, at the same time, we are unable to tell the exact condition going on inside the abdomen, and we are in doubt as to whether it is safe to operate at once, or whether it is safer to wait and see what happens later on. I have had various experiences with these cases. I have seen them under many different circumstances, and I have tried, as other men who practice surgery have tried, to figure out some sort of rule by which I could be governed in the management of these cases.

As has been stated by Dr. Brown, there is no medical treatment for appendicitis. It is a surgical disease, pure and simple, and it is an affection that usually comes to an operation, sooner or later. If a case does not come to an operation in the first attack, it will either come to an operation or to a funeral in some subsequent attack. I know of one patient who was said to have had sixteen attacks of appendicitis before he underwent an operation. Even though patients may recover from one or two or three attacks, we may rely upon the conclusion that they will have other attacks. We cannot consider them cured when they recover from one or two or more attacks.

Speaking of the cases that recover without operative treatment, I think they could be more safely handled if they were operated upon in the interval. I believe that every surgeon of experience will admit that an operation in the interval of health, after the patient has recovered from one or more attacks, is the safer, but I want to tell you of one point upon that ground. It is a practical point, namely, that when patients recover from an attack, they will not allow you to operate. They will not have an operation. They will say to us, "I am well; I don't need to be operated upon." They do not and cannot understand the certainty that hangs about them of precipitating another attack. Therefore, I consider this a very strong argument against advising patients to wait and have an interval operation during the interval of health.

It has been admitted by Dr. Mitchell in his paper that the great danger attending these cases, if not operated upon, is septic peritonitis. That, I think, is admitted by the other gentleman who has read a paper. I want to say in that connection, that if these patients do get diffuse peritonitis, an operation will do more harm than good. I have taken the position once before in this Society on that point, that an operation upon a patient who already has septic peritonitis is contraindicated. While it is possible that a patient may occasionally be saved by operation who has septic peritonitis, I think the instances are extremely few, and that the majority of them will go right on and die. We cannot make the public believe that

most of the cases operated on for diffuse peritonitis have not died from the operation. The laity think that the doctors have killed such patients, and we cannot get them to believe otherwise. They are not ready to believe that these patients would have died anyway. This impression among the people deters many patients from being operated upon whose lives could be saved. The interval operation is a safe one in nearly all cases, except in those with diffuse peritonitis, and in those instances it is worse than useless to try and save them by operative measures. If we operate on cases of diffuse peritonitis, it deters many patients from undergoing operations that might be saved, and it brings odium upon surgery.

My conclusion has been, after considering the various phases of appendicitis, that if patients have not already got diffuse septic peritonitis, we had better operate. If we can get the appendix out before an abscess has formed, the operation is safe. When an abscess has already formed, and we cut into it, after washing it out and draining it, it is safe, and, therefore, I believe we ought to operate on those cases that are not complicated by diffuse septic peritonitis as soon as we can.

**Wm. W. Williams**, of Quincy: I think appendicitis is purely a surgical disease. If it is a surgical disease in the beginning, it is undoubtedly a surgical disease all the way through, and if we operate during the first twenty-four or forty-eight hours, we can save patients almost invariably. On the other hand, if we wait until general peritonitis sets in, we save very few of them. The majority of them die. I have been called in consultation with good physicians and have advised operations. They would say, wait, and I have frequently waited because I was overruled, the result being that we would have a funeral in a few days. I have operated on fifty cases of appendicitis in all stages of the disease, and I have lost one case from gangrenous peritonitis. I have saved two cases of general peritonitis, and that being the case, I cannot endorse any paper except it is on the surgical treatment of this disease in all stages.

**Charles B. Brown**, of Sycamore: As is usually the case in discussing appendicitis, we go over the entire field. The title of the paper is, "When shall we operate on cases of appendicitis?" Does the author mean that we must operate on this or that case just as we happen to see it? The time to operate is when the patient has appendicitis. If a patient is held until pus forms, or until some good clergyman is found around the country, it is not a good time to operate. Now, if Dr. Ochsner saves one-third of the cases in the interval, he would have saved all of them if he had operated when the patients first had the disease. The time to operate upon a patient is when he or she has appendicitis, and statistics will prove that the results are better than at any other time. No man can tell when to operate upon this or that case; the individual who sees the case must be the judge as to the time when to operate.

**Seth T. Hurst**, of Greenview: I suppose that there is no disease which has been so much written about in the last few years as appendi-



chitis, and from the numerous articles we have read on the subject, in which large numbers of cases have been reported, we have learned a great deal. Every country practitioner, of which I am one, has had his share of experience with this disease. In the town in which I live I have had fifteen or twenty cases in the last fifteen years, which were diagnosed as appendicitis soon after the disease was brought prominently before the profession. Since that time, however, I have seen several cases that were not recognized as appendicitis, and in one of them I had the privilege of making a post-mortem examination, which demonstrated gangrenous appendicitis, with rupture of the intestine from general peritonitis.

I recall the case of a little girl who had had two attacks of appendicitis. In a third attack I was called to see her. The parents had never had a physician for her in the previous attacks. The third attack became rapidly active, and the parents hesitated about an operation until I said it must be one of two things: The little girl must be operated upon, or die, and the quickest way to do it is to have her taken to the hospital at Jacksonville, and operated upon. She was moribund when the operation was done, and died from shock soon after. With that exception, I have seen patients operated on in almost every stage of the disease recover.

I remember the case of a young man, of fair constitution, a minister of the gospel, who had his first attack, and within one hour he was so sick and in such a condition that he could not be moved. After two weeks of poulticing and high enemas, etc., he recovered, got up and about.

All cases brought before us as cures without operation are simply expectant cures, because we do not know when patients will have recurrent attacks. This young man, about three months later, came back from his work, was taken sick the second time, Dr. Mammen operated on him, and he is well today.

I recall the cases of two young men, one about 13 years of age, the other about 11, both of whom have had an attack of appendicitis, one of them during the last six weeks. Neither of them is well, and the parents have been given to understand that the boys are not cured, but that they are liable at any time to have recurrent attacks; that there must be done an operation, and yet in the meantime between the attacks they refuse operation.

**Edward H. Ochsner**, of Chicago: Dr. Mitchell has so thoroughly gone over the system formulated by my brother, that I can scarcely add anything to it. However, Dr. Harris has brought out a point which is of great importance. In some one of the discussions, it was urged against my brother's treatment that the expectant plan was prone to cause pyemia, metastatic abscesses of the liver, and of other portions of the body. I do not think that statement is correct. I do not think that special method of treatment will prevent those complications, but I do believe that with this special method of treatment the complications mentioned will be less frequent. A case in point is the first one Dr. Harris has so

thoroughly given a history of. The patient was operated upon on the third day, and not because of the operation, but in spite of the operation, metastatic abscesses of the liver developed. I have no doubt if that patient had been allowed to wait and had been given the other method of treatment, he would not have had appendicitis of the same severity. I would simply make the statement that metastatic abscesses in the liver may occur just as well where a patient is operated upon within the first three days as where the expectant treatment is permitted in those cases where an operation cannot be done in the first thirty-six hours.

**Jacob Frank**, of Chicago: I wish to say, in connection with the papers that have been read, that high rectal enemas do not prevent peristalsis. I have a case in mind where beef tea was injected into the rectum and the patient vomited. I saw the report of a case of that kind published in a medical journal in New York, where food given by the rectum was vomited. I do not think we have any reliable evidence to prove that high enemas cause general septic peritonitis. Patients who have a localized peritonitis will sometimes manifest more severe symptoms than those who suffer from a general peritonitis where the abdomen is full of pus.

I would ask the Doctor what he means when he speaks of the acute stage passing off? Does he mean that in a patient who has septic peritonitis, with the abdomen full of pus, whose pulse is materially lowered, that the acute stage has passed off? I have operated on patients with septic peritonitis who had a normal temperature and normal pulse, yet, when the abdomen was opened, the belly was found full of pus.

In my operative work, I have never seen a patient recover from a general septic peritonitis, whose abdomen was full of pus. I take it for granted, that when we speak of a general peritonitis, we mean a condition in which every coil of intestine is involved.

**H. C. Mitchell**, (closing the discussion.) In closing this discussion, it seems that I failed to make myself thoroughly understood to some of the gentlemen who have participated in the discussion. E. J. Brown stated that the essayist said that the time to operate is after the inflammation has passed beyond the appendix. I stated exactly the reverse of that. My contention is, that we should operate on all cases, if possible while the infection is confined to the appendix, which is usually during the first 36 hours. After that period, when the infection has passed beyond the confines of the appendix, I advised letting the patient take his chances of spontaneous recovery until the acute stage has passed, and operate after the patient had convalesced. I believe that thousands of patients die annually because they are operated on in the stage I have just described, when if they had not, they would have passed on to convalescence, when they could have been operated on safely. I agree with most that Dr. Grinstead has said. The doctor has said that he didn't believe that a case of general peritoneal infection should be operated on, as they



nearly all died, I agree with him that the great majority of these cases should not be operated on, particularly such, as have passed into a state of collapse. But I could not agree with the statement, that no case of general peritoneal infection should be operated on, because such a large per cent of them die that it brings odium on surgery. I do not understand that we operate at any time to tickle the surgeon, but we operate to save the patient. The surgeon's mission is one of life saving, and if we can only cure one case of general peritonitis in a great many, we have accomplished that much. I think we should operate on all cases of that kind that have good vitality, and show no signs of collapse. Dr. Williams of Quincy, has stated that, if we wait until general peritonitis sets in that very few cases will recover, if he will try the plan of treating his patients by the Ochsner method, he will have almost no cases of general peritonitis to treat, and that nine out of ten of his patients will pass to convalescence, in a few days. Dr. Brown of Sycamore, has stated that if Dr. Ochsner, saved one-third of his cases in the interval, that he would have saved them all, if he had operated at once. Dr. Ochsner lost only one patient in nearly four hundred, less than one-third per cent, which is less than any other operator can show by far who operates on his cases in all stages. He has reduced the mortality rate very decidedly by his method. It is true that a great per cent of these cases will have gangrene of the appendix, or a circumscribed abscess, but nature in the majority of instances will take care of the gangrenous appendix by absorption, and the abscess will rupture through the bowel. If it should not, and the symptoms should continue to grow more aggravated, you could then operate. I have seen a great many cases of circumscribed abscess and gangrenous appendix operated on, and the case die of peritonitis, resulting from being infected at the time of the operation, when if they had been allowed to convalesce, and be operated on in the interim, they would now be living. And I want to close my remarks by saying that, I think it not only a lack of conservatism, but sheer folly to operate on every case of appendicitis we are called to treat in all stages regardless of conditions.

## LIFE INSURANCE EXAMINATIONS.\*

BY H. B. BUCK, M. D., SPRINGFIELD.

1st—Policy demands that every accepted duty be done in a thorough, painstaking manner, irrespective of size of fee.

That honesty is the best policy admits of no argument; that in all legitimate business lines the employee should guard the interest of his employer; that every honest examiner cannot lose sight of the business aspect involved, and will look upon each application

as representing money value according to the figures.

He must also fully realize that the home office sees the applicant only through his eyes; that upon him devolves the duty of constructing a health chart showing all obtainable facts, so sifted as to furnish the necessary data for a business decision.

The nearer he approaches perfection the greater the service and the more effectually he guards his own reputation, which, next to the desire to render a full equivalent, should always prove a controlling motive. Such service merits fair compensation.

The option lies with the examiner to refuse service when the size of the fee suggests such a low estimate of the value of selection as to stamp the organization bogus. To refuse service for a ridiculously small fee at least has the merit of an attempt to shield the multitude taxed for the sole benefit of the few.

Among companies working on a business basis, fees vary somewhat, but all allow a fair compensation and demand honest work. No self-respecting examiner will risk careless, unprofessional service, and can ill afford to append his signature to work that will not bear both present and future inspection.

2nd—That anything short of honest, painstaking work reflects discredit upon the entire profession.

No one man (it matters not how perfect his work) does enough of this service to furnish a basis for estimating how much might be accomplished in the line of medical selection.

The general data must result from combination effort.

It follows that any deficit or failure to meet expectations, is chargeable to the profession at large.

As compared with general mortality, insurance companies rightfully expect a difference, even if risks included all ages and sexes.

Since both very young and very old are excluded, they expect a very marked difference. The only hope of improvement must come through universal recognition

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

of the fact, that each examiner is a component part of a complex body, and that the welfare of that body is, so to speak, in the care and keeping of every individual composing it.

3rd—That suspicion as to the honesty of the profession (entertained by the insurance companies) can only be remedied by widespread, individual effort; each fully realizing that his service either tends to weaken or strengthen that suspicion.

While I would guard against crippling ambition by fulsome flattery, I am free to say that this suspicion is not so much the want of confidence in ability as lack of confidence in the honesty of the profession. Too often the character of the service rendered warrants this criticism.

Notably, evidences of haste, important omissions, want of due consideration, leaving vital points with bare mention, without explanatory data, indispensable for business decision. These at a glance might be regarded of minor importance, since, at the expense of delay, dissatisfaction of the expectant applicant, to say nothing of the annoyance, extra trouble and expense, the work is finally made passable; still the fear remains that such indications may not be the worst defect; that points of more vital importance have been passed unrecognized to loom up in the near future and furnish full proof of my next proposition.

4th—That truly careful and scientific work would lessen the percentage of premature deaths, from diseases of lungs, heart and kidney.

In other words, either carelessness, undue haste, or both, may result in overlooking incipient evidence of diseases that by and through rapid development and fatal issue, furnish too many early proofs of death.

Statistics show a percentage of mortality during the first twelve months of insured life that can hardly be accounted for on any other hypothesis.

Gallopings consumption does occur, but the greatest majority of cases show a lingering tendency.

Acute kidney inflammation sometimes runs

a rapid course, but on the whole, kidney diseases show a chronic but markedly fatal tendency.

With all companies (except sub-standard) the rule is to decline all applicants showing heart lesion. I doubt not injustice is often done for want of a critical, differential diagnosis. Tuberculosis, diseases of the heart and kidney, and I might add apoplexy, furnish the diagnosis in the majority of these early fatalities.

In reviewing these proofs of death, I have generally remarked the satisfactory showing upon the health chart upon which the application was approved.

As a rule nothing to show impending danger; what is the natural inference? From diseases of acknowledged lingering character, ought such results to be so soon expected.

Expense was incurred in every case, the whole aim and object being careful medical selection. Marvel not that distrust is a consequence. What, I ask, is the remedy? There can be but one answer. Exclusion by redoubled diligence; more careful scrutiny; a halt on hasty, superficial service should be called. Render full equivalent by making an honest, thorough professional report, and thus regain lost confidence.

Having shown the secret of this untoward showing, I propose later to enlarge upon the character of examinations that should prove the remedy. This comes more properly under second part of my fifth proposition.

5th—The necessary qualifications for and the technique of the work.

To accomplish results fore-shadowed, need of high grade work becomes apparent.

Efficiency requires expertness in diagnosis, etiology and prognosis; mental alertness, the faculty of close observation, so keen that early evidences of disease will not escape notice. Tact, natural shrewdness, a deep sense of moral obligation, and above all, unflinching honesty and integrity make the full equipment of the ideal medical examiner.

He must not, however, accept an appointment of a disbeliever in insurance as a business proposition. Fealty to the business interests of the company is of paramount

importance. This does not preclude gentlemanly treatment of the solicitor, to whom should be shown the spirit of accommodation, taking into account that promptitude favors his business interest. This seems the proper point for a word of encouragement, by announcing that the companies know the value of a good examiner, and have learned the necessity of giving him full support. They put him beyond the will or wish of the agent and thus shield him if compelled to have dealings with such as may be over-influenced by cupidity. His appointment, upon satisfactory credentials, issues direct from the home office; he can feel assured that his tenure of office is safe as long as he meets requirements. Special effort is made to confine all work to regular appointees.

Bear in mind that seeking pathological derangements in the ordinary patient whose interest prompts obedience to every wish and who spares no pains to make himself an ally in the hopeful search, is quite a different proposition, compared with ferreting out imperfections that do or may affect life expectancies, and that too, not only without aid, but against all the opposition that selfishness brings to bear in the line of concealment. This work furnishes full scope for diplomacy, character reading and suggestion.

Ability to entertain, interest and so utilize the applicant as to obtain all items necessary to constitute a reliable health chart marks the politic and successful examiner.

All else being equal, the best examiner is he who best appreciates the wants of the home office; who can best anticipate all inquiries that will naturally arise from the presentation given; who will supply details necessary for a business decision and thus forestall the necessity for explanatory amendments. He will not overlook points that may arise not provided for by the limited blank, and thus show his adaptation to this service. All work must be done in ink. Legible writing only is called good. Figures should be clean cut. The first touch of pen is recording name, which should always be written in full. In signing, allow accustomed signature.

Mistakes that will occur, should not be

erased but simply ink-lined, correction made and initialed, to show ~~same~~ your own and not that of some interested party.

Technique must be made a study; all the parts well timed; thoughtfulness must pervade the entire work; no answers given, leaving room for doubt as to the intent. Let all be direct answers, excluding dashes, crosses, ditto marks. The fee is not paid for opinion as to importance or non-importance of questions purposed, but for unequivocal answers to each and every one. Absolute rotation in blank is right with one exception. By choice of proper time, use judgment in getting natural pulse rate. The nervous temperament who has passed the ordeal of weighing and getting height and other measurements, including chest expansion with efforts made for a good showing, is farthest from the condition to show a natural pulse rate and heart action.

Filling first page of blank gives full opportunity to practice the art necessary to so impress and interest the applicant as to allay fear and excitement. Take pulse rate and observe heart action as the first step upon turning to the strictly medical side of blank. At all events choose a period of quietude and to guard against omission record findings at once.

At first glance these might, by some be considered minor points, but experience acknowledges and appreciates their importance. No difference how assuring external appearances, no prudent examiner will forego the tests necessary to confirm his preconceived judgment.

Carelessness is hardly a crime, but a great misfortune to one ambitious for success. Studied method is a necessity; it effects a critical examination of every organ with even economy in time.

Laxity in claiming full opportunity is a fatal omission; many times the secret of costly blunders.

The heavy underwear and stiffly starched shirt, was chargeable for failure to catch the heart murmur, that observed, would have protected against loss by that premature sudden death.

The same covers up early evidences of



lung trouble, that by bare chest examination, would have attracted fixed attention.

The single finger point upon the pulse estimates number of pulsations; notes any irregularity; but three fingers are required to estimate force of blood current and determine condition of arterial coats.

The finger nearest the heart tests force necessary to obstruct the flow, while remaining fingers by a rolling motion of the artery tests whether flaccid and yielding, or shows so-called sclerotic degeneration.

The expert finds evidences of insidious kidney disease, before its ravages are even suspected by the victim. It can be safely predicted that this condition of blood vessels, associated with kidney disease, will early show heart complication; hypertrophy of left ventricle, the natural result of pumping against inelastic resisting arteries.

The detection of this hardened condition of blood vessels, necessitates a diligent search for basic trouble. Without disease of kidneys it bodes evil; these subjects, furnishing their quota of premature deaths by apoplexy.

The thoroughly trained are ever watchful, taking nothing for granted and thereby make discoveries that even surprise the applicants. Light weights with evidences of malnutrition arouse suspicion and call for rigid inspection. If deemed insurable, the report should distinctly state whether light weight was a personal or family characteristic, in exceptional cases with family details upon this point. Remember also that heavy weights are not exempt. Such with an outward show of health have been found in the active stage of tuberculosis.

In the early proofs of death this fell destroyer takes the lead.

Without proper facilities and full opportunity for critical work, few important discoveries redound to the credit of the examiner.

The blank strictly followed will bring out history of applicant's past experience with either accident or disease.

To facilitate the work by obviating the necessity for explanations, every report showing previous appendicitis should clearly state

whether treated medically or surgically, and if by the latter, whether appendix was removed or pus cavity merely opened and drained.

Rheumatism demands statement as to kind and locality; whether articular or muscular; whether any objective signs remain and of what character; in every case heart complications found, and when none is found, a statement even to that effect. This evidences thoughtful work.

These are instances of the thoughtful procedure that should be followed upon all important points elicited, thus furnishing a report that effects or allows final disposition of the case without delay.

Words fail to estimate importance of family history. Both judgment and care is necessary to dispel haziness of applicant's memory; to checkmate the possible intentional use of vague, indefinite terms, by prying into details of sickness and death, in the search for cause that will fit, and thus at least approximate the truth. Witness list of terms so often accepted and reported, viz: exhaustion, exposure, complication of diseases, heart failure, dropsy with no inkling as to cause, etc., perfectly valueless for classification or tracing hereditary. Faithful, intelligent work demands and obtains full recognition.

#### URANALYSIS.

Time forbids more than simple mention of errors likely to occur through imperfect uranalysis; failure to apply proper confirmatory tests of precipitates found and as a result, report doing injustice to the applicant.

Haziness from boiling test is not always from albumin. Nitric acid precipitates albumin, nucleo albumin, mucin, urea, acid urates and resins if present. Careless haste might precipitate a wrong conclusion.

Potassium ferro cyanide would be the better test, since it precipitates albumin only.

Potassium mercuric iodide and citric acid tablets are convenient and less likely to confuse. Precipitate may be albumin, peptone or some alkaloid.

In case of morphine habit or treatment of

some chronic ailment with alkaloids, this test might give a valuable cue, that would arouse in applicant a healthful respect for our calling.

Heat dissipates peptone. Alcohol dissolves the alkaloids, neither of which affects coagulated albumin.

Sugar test with indigo and soda tablets is more delicate and better adapted to detection of incipient troubles.

One point most important is to know that specimen examined is genuine or voided by applicant.

In conclusion, if my desultory remarks serve to stimulate investigation in the line of catching earliest manifestations of disease, I shall feel more than compensated, and with unfeigned pleasure will hail the day when the benefits of medical selection more clearly demonstrate the skill of the medical corps.

#### Discussion.

**B. B. Griffith**, of Springfield: I wish to thank the doctor for the very able paper he has presented. It is a subject in which many of us are interested, and the doctor has considered it from the standpoint of the medical director of an insurance company. Some of his remarks are perfectly correct, and I concur in them. Some of them, however, I cannot possibly consent to. It is a well-known fact that the life insurance examiner is asked to do a great deal of work for a small compensation, but he, after all, is the one to decide whether he will take it or whether he will not take it. The insurance companies try to get as much as they can for as little as possible. The quality of the service rendered is largely governed by the careful selection of an examiner. His ability and discrimination are looked into very carefully. The insurance companies expect honest work from the physician, and the man who can do their work satisfactorily must be honest in his expressions. Dr. Buck's paper is worthy of much consideration, and I think that if more of the medical directors of the insurance companies would look into this matter, and consider it from the examiner's standpoint, instead of that of the company, influenced by the medical department of an insurance company, the fees for life insurance examinations would be more equable, and probably higher than the fee paid now.

**S. T. Hurst**, of Greenview: One factor was overlooked by Dr. Buck in the preparation of his paper, one which might have been more fully considered, and that is the interest of the agent in soliciting life insurance. He is largely concerned, and always looking for his share of the profits. On the first part of an insurance examination are the applicant's statements made out by the agent, and the

first question asked of the physician is, "Have you read the answers to questions so-and-so?" Something the physician has no business with whatever. It is not at all pertinent for him to know what the applicant said to the agent, neither has the agent any business to know what the applicant said to the physician, or what the physician says to the medical director. I believe that all examinations should be sent directly to the medical director and not to the agent.

It is also very disagreeable to have the agent present while the physician is examining the applicant, and I have been frequently interrupted in my work, so that I was obliged to request the agent to please absent himself from the room. When you ask certain questions to which the agent does not like to have the applicant give the correct answer, he will often say, "Oh, that makes no difference. His grandparents died from such and such a disease," when from the examiner's standpoint it often makes a great deal of difference. When a man lives in one neighborhood for many years, he comes pretty near knowing something about the ancestors and family history of every individual in that neighborhood.

No life insurance examination should be made for less than \$5.00. The physician should not know anything about what the applicant has said to the agent, and all the examiners should deal directly with the home office and not with the agent. Of course, the medical examiner is usually appointed through the offices of the agent, but that has nothing to do with the applicant, and does not bind the physician in any way to the agent.

**J. H. Stowell**, of Chicago: I wish to commend Dr. Buck's very admirable paper, and I approve heartily of his recommendations. It should be understood, however, that the fee paid to the medical examiner is not estimated by the value the medical director places upon the services of the examiner. The insurance fees are regulated by the offices of the company, and they fix a fee that soon becomes common with all the life insurance companies. In most cases medical directors would be willing to pay an adequate fee, but they are not empowered to change the regular fee of the company. It is a sad fact, that many of the papers that come before the medical director are not worth much. Many of them are very poorly written, and illegible, and others are carelessly made out. If we could have men who are interested in their State societies, interested in the progress of medicine, make our examinations in all cases, we would have very little trouble. Our blanks could be shortened, and we could practically leave it to those men who are trusted and honest, men who keep up in and abreast with their profession, to decide as to whether or not the insurance should be issued. Unfortunately, we must in many cases depend upon examiners who are not well qualified, simply because there is no other physician in the neighborhood.

I also believe strongly in having instruction given in our medical institutions as to

how to conduct a life insurance examination. In some institutions that is being done. George H. Webster gives such a course of lectures in the Chicago Medical College, and the graduates of that institution have a thorough knowledge of what it means to examine for life insurance. If that matter could be encouraged so that all our colleges would take it up, we would have better life insurance examiners. So many cases of kidney, heart and lung diseases go undetected until the death of the applicant is reported at the home office, and when the inspectors are sent to make an investigation into that loss, it is found that in many instances a very careless and superficial examination was made. If it had been made carefully, the company would, beyond doubt, never have assumed the risk. Such cases as this lower the estimation of the insurance company, so far as the physician is concerned.

**Dr. Buck** (closing the discussion): In answer to the remarks made by Dr. Hurst, I wish to say that the method of examining he refers to differs very materially from that which pertains in our company. The blanks are entirely different in my company, the two sides of the blank being filled in by the examining physician. The agent has nothing whatever to do with the applicant beyond getting his application. I think that explanation will answer the criticism that he made in regard to the blanks.

It is astounding when you look at the evidence we have of what must be absolute carelessness on the part of the physician in the examination of some cases. There ought to be a change. More time should be taken by the examiner. We ought to give both the applicant and the company the full benefit of a good honest examination, and if we did that, the character of the profession would more nearly come up to the standard that would please the life insurance company.

**Dr. Hurst.** How much time do you think is required by an expert examiner to make a thorough examination and reach a decision?

**Dr. Buck:** That will depend entirely upon the examiner and the method he uses, and how careful he is in the consideration of all the answers that the applicant may make, and how much truth there is in them.

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## PROCEEDINGS ILLINOIS STATE MEDICAL SOCIETY.

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Minutes of the Fifty-Second Annual Meeting  
Held at Quincy May 20,  
21 and 22, 1902.

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### MAY 21ST—SECOND DAY—MORNING SESSION.

The Secretary read a resolution from Section One, offered by James H. Stowell, to the effect that this Section take steps to

secure standard, uniform strength of anti-toxin by the national government.

On motion of Dr. Brower, the report was adopted.

Under the head of "Unfinished Business," Dr. Carl E. Black presented the report of the preliminary meeting, as follows:

#### REPORT OF PRELIMINARY MEETING.

Carrying out the call of President McAnally, the preliminary meeting of the State Society was held in the Court House, Quincy, on the Monday preceding the opening of the regular annual sessions.

The meeting was called to order at 2 P. M., by Dr. Carl E. Black, chairman of the Legislative Committee, and upon motion President McAnally was elected chairman of the meeting.

The first order of business was the presentation of the report of the Committee appointed last year to revise the Constitution and By-Laws.

This report was presented by the chairman of the committee, Dr. E. Fletcher Ingals, of Chicago. It was first read in its entirety, and then taken up section by section. After free discussion, each section was formally adopted, and at the conclusion of the discussion the whole Constitution and By-Laws were unanimously adopted by the preliminary meeting, and recommended to the general session of the Society for their consideration and adoption.

Secretary Weis presented a resolution by Dr. Fenton B. Turck, with reference to introducing into medical colleges practical instruction in dietetics, physio-mechanical therapeutics and hydrotherapy.

On motion, this resolution was laid on the table, and recommended to the Society for a similar action.

The Secretary read a resolution by Dr. Kyger, of Kansas City, Mo., asking that the meeting take some action relative to the abolition of objectionable advertisements in newspapers.

On motion, this resolution was tabled.

Dr. James A. Egan, member of the Committee on Legislation, called attention to,



certain defects in the State Board of Health act. As Secretary of the State Board of Health, he pointed out that these defects were (1) that the State Board of Health has no authority at present to impose a penalty for the violation of an act. (2) There is no law giving the Board the power to require local boards of health to enforce its rules.

He asked and urged that the meeting endorse his suggestions in regard to a bill for extending the scope of the State Board of Health.

Dr. Carl E. Black offered the following:

Resolved, That we endorse the suggestions for a bill, providing for improving and widening the scope of the Illinois State Board of Health, as outlined by its Secretary, Dr. J. A. Egan, and that we recommend to the Illinois State Medical Society that the State Board of Health bill, drafted by the Secretary of the State Board, in consultation with his colleagues on the Board, be adopted, and that our Legislative Committee be instructed to lend any aid which it can in securing the passage of the bill at the next session of the Illinois Legislature. On motion, the resolution was adopted.

On motion, the meeting adjourned until 7:30 P. M.

The meeting was called to order at 7:30 P. M. by Chairman McAnally.

Dr. Carl E. Black, in behalf of the Legislative Committee, stated that, following the instruction of the State Society at its last meeting, in Peoria, his committee had drafted a new bill for the establishment of a State Board of Medical Examiners. He stated that the committee had tried to give this matter their most serious attention; that the medical practice acts of almost every State in the Union had been read and studied, and the best points contained in each selected for incorporation in a bill for the regulation of the practice of medicine in Illinois; also that the chairman of the committee had carried on an extensive correspondence with the secretaries of all the State Boards of Examiners in the United States, asking them to point out the strong and weak points of the laws under which they operate; that

some very valuable assistance had been received in this way. Further, that the chairman of the committee had corresponded with every member of every local society in the State of Illinois, asking for suggestions regarding such an act, and that many replies had been received to these letters, giving the committee valuable suggestions. It had been the one wish of the committee to secure, as far as possible, the consensus of opinion of the physicians of Illinois as to what should be contained in a new medical practice act. He also said, before presenting the proposed bill drafted by the committee, that it should be distinctly understood that it was not yet in legal form, and that it was the purpose of the committee, after the bill was discussed by the preliminary committee, to place it in the hands of some competent attorney or judge, to be put in legal phrase, and to see that it does not contain legal errors or conflicts. For this reason the committee had given only slight attention to the wording of the bill.

The bill framed by the committee was then read in its entirety. Following this it was read section by section.

Each section was fully discussed and formally adopted, with such changes and correction as the meeting desired. The bill, as corrected, was then unanimously endorsed and recommended to the general session of the Illinois State Medical Society.

THE PRESIDENT: You have heard the report of the preliminary meeting as read. What will you do with it?

DR. DANIEL R. BROWER: I move the adoption of the report of the preliminary meeting as read. Seconded.

DR. J. W. PETTIT: I do not wish to be technical, or to take up the time of the Society unnecessarily, but I wish the committee might be allowed wider latitude than this motion simply gives them. I therefore move, as a substitute, that this matter be placed unreservedly in the hands of the Legislative Committee, with power to act, as they may deem proper, either to introduce the bill that has been presented, or some other bill, as in

their judgment seems best. I offer that as a substitute. Seconded.

The President put the substitute, which was carried.

THE PRESIDENT: We now come to the reports of officers. The first will be the Secretary's report.

The Secretary read his report as follows:

SECRETARY'S REPORT.

*To the President and Members of the Illinois State Medical Society:*

Your Secretary takes leave to report that all the papers that were read at the last annual meeting with the discussions thereon were received and after editing the same were transmitted to the editor and were published in the Journal.

Pursuant to a resolution covering the same, the abstracts of the papers of this meeting were received by me and transmitted to Kreider.

Agreeably to a resolution adopted at the last meeting, your Secretary has caused to be printed five hundred copies of the Constitution and By-Laws, together with the report of the Committee on Revision of the Constitution and By-Laws, at a cost of \$27.50, which same have been brought here for distribution.

Returning to the old custom of mailing a copy of the printed program to each member of the Society, your Secretary caused to be printed two thousand copies of the official program, of which one was mailed to each member of the Society, one to the secretary of each State Society and quite a number to physicians who were not members of the Society. The balance were brought here for distribution, the cost of same being \$28.50.

Owing to the inability of your Committee of Arrangements to decide upon the location for holding this meeting, it became necessary in December last for your Secretary to proceed to Quincy to determine that and to assist the said committee with his advice and suggestions.

Acting upon the suggestion of the Nominating Committee at Peoria last year that the Society shall hold simultaneous meet-

ings of the Sections and the Executive Committee having ordered the same, it became necessary to secure the services of an assistant official stenographer so as to preserve the discussions of the Sections. Last year a part of the time two Sections held simultaneous meetings and your Secretary regrets to report that by reason of the fact that there was no efficient stenographer procurable at the place of meeting, some of the most important discussions of Section One were lost. No provision having been made at the last meeting for the services of an assistant, the Publication Committee assumed the responsibility of procuring an assistant and ordered the same for this meeting. The exact cost of such services cannot now be stated, but we wish our action endorsed.

Respectfully submitted,

Edmund W. Weis,

Secretary.

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A PRACTICAL MANUAL OF INSANITY.

For the Student and General Practitioner.  
By Daniel R. Brower, A. M., M. D., LL. D., Professor of Nervous and Mental Diseases in Rush Medical College, in Affiliation with the University of Chicago, and in the Post-Graduate Medical School, Chicago; and Henry M. Bannister, A. M., M. D., formerly Senior Assistant Physician, Illinois Eastern Hospital for the Insane. Handsome octavo of 426 pages, with a large number of full-page inserts. Philadelphia and London; W. B. Saunders & Co., 1902. (Cloth, \$3.00 net.)

This valuable volume, the product of two of the leading neurologists in the country is one which can be recommended to all our readers. Owing to the want of suitable hospital facilities in this country our colleges have been in the past, sadly defective in teaching students even the simplest facts concerning insanity and nervous diseases. For this reason a manual such as this will we believe fill a long felt want.

# The Illinois Medical Journal.

The Official Organ of the State Medical Society.

EDITOR—George N. Kreider, A. M., M. D., Springfield.

Official Reporters of Affiliated Societies—

## COUNTY SOCIETIES.

Adams County—Henry Hart, M. D., Quincy.  
Alexander County—J. T. Walsh, M. D., Cairo.  
Bureau County—H. E. Owens, M. D., Princeton.  
Bond County—W. T. Easley, Greenville.  
Carroll County—H. S. Metcalf, M. D., Mt. Carroll.  
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McDonough County—R. E. Lewis, M. D., Macomb.  
Macoupin Co.—J. Palmer Matthews, M. D., Carlinville.  
McLean County—E. S. Reedy, M. D., Bloomington.

## DISTRICT SOCIETIES.

Aesculapian—H. McKennan, M. D., Paris.  
Brainerd District—J. L. Lowrie, M. D., Lincoln.  
Central Illinois—F. J. Eberspach, M. D., Pana.  
Galva District—C. W. Hall, M. D., Kewanee.  
Fox River Valley—H. J. Gahagan, M. D., Elgin.  
Military Tract—C. B. Horrell, M. D., Galesburg.  
North Central—Geo. A. Dicus, M. D., Streator.  
Southern Illinois—O. B. Ormsby, M. D., Murphysboro.  
Tri-County—Leroy Jones, M. D., Hoopston.

## URBAN SOCIETIES, EX CHICAGO.

Alton Medical Society—Geo. E. Wilkinson, M. D., Alton.  
Decatur Medical—Lynn M. Barnes, M. D.  
East St. Louis—C. W. Lillie, M. D.  
Jacksonville Physician's Club—D. W. Reid, M. D.  
Peoria Medical—E. M. Eckard, M. D.

Marshall County—  
Massac County—C. E. Trovillion, M. D., Metropolis.  
Mercer County—A. N. Mackey, M. D., Aledo.  
Montgomery County—J. M. Trigg, M. D., Farmersville.  
Morgan County—T. A. Wakely, M. D., Jacksonville.  
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Ogle County—H. A. Mix, M. D., Oregon.  
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Pope County—W. S. Dixon, M. D., Rosebud.  
Pulaski County—Chas. J. Boswell, M. D., Beechwood.  
Richland County—M. D., Olney.  
Saline County—J. R. Baker, M. D., Harrisburg.  
Sangamon County—M. D., Springfield.  
Schuyler County—A. W. Ball, M. D., Rushville.  
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Stark County—M. T. Ward, M. D., Toulon.  
Stephenson County—R. J. Burns, M. D., Freeport.  
St. Clair County—B. Portuondo, M. D., Belleville.  
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Union County—T. Lee Agnew, M. D., Anna.  
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Wabash County—J. B. Maxwell, M. D., Mt. Carmel.  
Warren County—Adella R. Nichol, M. D., Monmouth.  
White County—W. A. Steele, M. D., Carmi.  
Will County—Herbert S. Worthley, M. D., Joliet.  
Williamson County—G. W. Evans, M. D., Marion.  
Winnebago County—S. R. Catlin, M. D., Rockford.

## CHICAGO SOCIETIES.

Academy of Medicine—J. G. Kiernan, M. D.  
Electro-Medical—Richard H. Street, M. D.  
German—Karl Doepfner, M. D.  
Gynæcological—C. S. Bacon, M. D.,  
Medical Society—F. X. Walls, M. D.  
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Neurological—C. H. Lodor, M. D.  
Ophthalmic and Otolgical—Brown Pusey, M. D.  
Orthopedic—Edwin W. Ryerson, M. D.  
Pathological—Geo. H. Weaver, M. D.  
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Society of Internal Medicine—Robt. B. Preble, M. D.  
Southwestern—Thos. J. McGonagle, M. D.  
Surgical—D. N. Eisendrath, M. D.  
West—Gustavus M. Blech, M. D.

All communications should be addressed to the Editor, 522 Capitol Ave., Springfield, Illinois.

The Society does not assume responsibility for any statements or opinions published in the JOURNAL.

The JOURNAL is published monthly. The subscription price is \$3.00 per annum in advance. The JOURNAL is furnished free to the members of the Society.

Entered at the postoffice in Springfield as second class matter.

SEPTEMBER 1902.

## CENSUS REPORT ON PHYSICIANS AND SURGEONS.

Through the courtesy of Congressman Caldwell we have had the opportunity of examining advance sheets of the 1900 census report on the number of physicians and surgeons in the various states, territories and possessions, which latter include only Alaska and Hawaii. It is probable that an accurate census enumeration of Porto Rico and the Phillipines has not been made, otherwise

they would be included. We can give only a few interesting data. The grand total of practitioners is given as 132,225. Males, 124,826. Females, 8,126. This total is about 8,000 more than was given in our table of last January, and is probably to be explained by the enumeration, on their own statement of occupation, of the submerged 5 percent who practice *ex lege et tacito*. One is not engaged in practice very long before discovering this class of practitioners.



In Pennsylvania they usually appear in the guise of witch doctors; in Illinois there are a number of natural healers, baunscheidists, etc., osteopaths are also included. The census gives to Chicago 3,646 male and 548 female practitioners, a total of 4,194; to Peoria 119 male and 15 female, a total of 134; Quincy, M. 83, F. 13, total 96; Springfield, 73 M., 7 F., total 80; Rockford, 58 M., 12 F., total 70; E. St. Louis, 43 M., 1 F., total 44; Joliet, 56 M., 4 F., total 60. The total number for the State is: M., 9,055. F., 820. Total, 9,875.

#### EARLY MEDICAL JOURNALS OF CHICAGO.

In response to our request for a history of the beginning of medical journalism in Chicago, Dr. N. S. Davis has furnished the following letter. Its importance from a historical point of view can hardly be estimated:

Chicago, Ill., August 18, 1902.

To George N. Kreider, M. D., Springfield.

Dear Doctor: The first Medical Journal published in Chicago was commenced in 1844, under the name, "Illinois and Indiana Medical and Surgical Journal," issued once in two months, and contained from 60 to 90 pages of reading matter in each number. It was ably edited by J. V. Z. Blaney, who was the professor of chemistry and pharmacy in Rush Medical College, which had commenced its active existence the year previous. In 1848 it passed under the editorial management of John Evans, who after four years, was succeeded by W. B. Herrick and H. A. Johnson, by whom the name of the journal was changed to "North-western Medical and Surgical Journal," and was issued monthly. In 1854 or 1855, its editorial management and publication was committed to myself, and soon after, its name was changed to "Chicago Medical Journal." It continued under my charge until 1859, when I resigned my connection with Rush Medical College for the purpose of aiding the establishment of a medical college with a longer annual college term, a graded system of instruction, and at least one year of hospital clinical instruction before graduation.

As the medical journal had been, from its beginning, edited and published by members of the faculty of Rush Medical College in leaving that faculty I transferred it, with all its

accounts to Daniel Brainard as president of that college, and its publication was continued as an important monthly medical journal until 1872 or 1873. The second medical journal published in Chicago was commenced in January, 1860, under the name "Chicago Medical Examiner," owned and edited by myself. It was issued monthly, containing 64 pages of reading matter and devoted to the interests of the medical profession and especially to a better system of medical education. It was fairly well sustained without courting the patronage of medicine manufacturers or advertisements of any kind until the year after the great Chicago fire of 1871, when I transferred the Examiner to Frank H. Davis, who changed it to a semi-monthly issue under the same name. About that time a medical press association was formed and by its influence the Chicago Medical Journal and the Medical Examiner were united under the name "Chicago Medical Journal and Examiner" with W. H. Byford editor in chief and a staff of younger men as assistants. This arrangement continued a few years and after undergoing several changes in management it passed into the hands of the late S. J. Jones who published it several years and then discontinued it.

The next journal published in this city was the Quarterly Journal of Nervous and Mental Diseases, owned and edited by J. S. Jewell. It was a large-sized quarterly, on which he bestowed a large amount of time and mental labor for eight or nine years, and gained for it a very high reputation in both this country and Europe. But then his health failed so completely that he was obliged to transfer it to other parties who removed its publication to New York where it is still continued as a leading journal in the department of nervous and mental diseases.

Another fair-sized monthly medical journal was issued under the name "North-American Medical Practitioner," as the bulletin or organ of the Post Graduate Medical School of Chicago in 1889, and was continued with considerable vigor until the end of 1899. All the medical journals now being published in Chicago and belonging to the field of legitimate medicine, have had their beginning within the last 25 years.

Yours truly,

N. S. Davis.

65 Randolph Street.

#### QUACK ADVERTISEMENTS IN THE LAY PRESS.

An encouraging sign of the times is the following editorial from the Litchfield

Monitor of May 27th sent us by J. M. Trigg, secretary of the Montgomery County Society:

There are yet enough credulous people in every community to provide handsome salaries for traveling quack doctors. It is a mightily good rule to patronize home physicians, all of whom are men of high professional standing. The Monitor, in the future, will refuse to advertise for fakirs of any kind.

Dr. Trigg adds: This county has had its share of quack doctors, but by the actions of some, especially Guy W. O. Mitehner, it is agoing to be hard for them to get advertising in the columns of the lay press.

The medical society is keeping after the quacks as fast they can here.

#### NEW INCORPORATIONS.

The Secretary of State at Springfield has licensed the following corporations:

Dr. Milton H. Berry, Chicago, \$10,000; dealing in medicines and medical compounds; incorporators, George W. Waldo, John A. McKeown, and J. V. Norcross.

Dr. E. A. Bassett Medical institute, Chicago; capital, \$10,000; for the preparation of drugs and medicines; incorporators, F. P. Reynolds, Isadore Lasker and William Slack.

The Chicago Eclectic Medical company, Chicago, certifies to a change of name to the American College of Medicine and Surgery.

The Belgian Drug company, Chicago; capital, \$1,000,000; wholesale and retail drug business; incorporators, William C. Ballowitz, Herman J. Engholm and Carl E. Moehle.

### Correspondence.

Chicago, August 6, 1902.

Illinois State Medical Association,  
Springfield, Ill.

Gentlemen: I have read, with great interest, the draft of a proposed act establishing a board of medical examiners in this state and I think it a substantial improvement on the law as it now exists, but I notice one thing which appears to me to be a very serious defect; namely: the definition of "practicing medicine" within the meaning of the act.

It will, I think, be conceded, that this definition is the very substance of the proposed law. If it be fatally defective, then

the entire act must fall with it. Looking at this definition as a lawyer, I believe it to be unconstitutional in this that it is an attempt to unduly restrict the constitutional rights of the citizen of Illinois. Suppose, for example, the wife of a day laborer living in a town perhaps next door to a physician, should give her infant child a dose of paracetic. Here is no emergency, because the physician is accessible. It would be argued, and I think with irresistible force, to the Court, that the only purpose of the definition applied to the case given is, to compel the laboring man to pay a physician's fee. This, he may be unable to do, yet, his wife may well know that catnip tea or some other simple remedy, will effectually control the pathological condition, though, if she attempt it, she may go to the county jail. Again, I may not apply a piece of court-plaster to the cut finger of a member of my household if I be in reach of a physician. If such be the meaning of the act, then its terms are an intolerable invasion of the rights of American citizens, which the courts will never sustain.

It seems to me that if the phrase "in cases of emergency" were cut out of the definition, the definition would stand a better chance of being upheld by the courts.

In the act of 1885, the definition excluded services of anyone "in cases of emergency" or "domestic administration of family remedies." As a lawyer, I am inclined to think this definition far better from the constitutional standpoint than the definition in the proposed act, which is the same as the one now in the statute book. In short, it seems to me that the physicians of this state in endeavoring to make the definition more stringent are likely to destroy the whole act.

I trust I will not be misunderstood in the foregoing criticism as I am heartily in favor of legislation which will raise the standard of professional men whether in law or medicine in this state, and my suggestions are prompted by the desire to see a good law enacted and one which will stand fire.

I am myself a graduate of medicine and a lecturer in Medical Jurisprudence in one

of the medical schools in this city, so you may properly infer that my attitude is of the friendliest.

Yours very truly,  
Frank P. Blair.

—  
Jacksonville, Ill., Aug. 13, 1902.

George N. Kreider, M. D.,  
Editor of the Illinois Medical Journal,  
Springfield, Ill.

Dear Doctor: Yours of the 11th, containing letter from Frank P. Blair, regarding the definition of the practice of medicine, as contained in the memoranda for a proposed bill for the regulation of the practice of medicine and establishing a board of medical examiners in the State of Illinois, is received.

In reply I would say that this definition is taken from the law of 1899, verbatim, with the exception of the last clause of that definition, which refers to treatment by mental and spiritual means, and has no bearing on the point in question.

The committee several times considered the desirability of changing this definition, but hesitated to do so because the Supreme Court (in at least one case—*People of the State of Illinois vs. Jos. B. Gordon*, No. 2095) has expressed itself regarding this definition. The committee further hesitated to recommend any change in the definition because it was framed by an ex-judge of the Supreme Court, and by many is considered the most concise definition of the practice of medicine contained in any medical practice act.

A review of the definition of the practice of medicine as contained in various medical practice acts of United States, will show how difficult is the task of framing a just, concise and comprehensive definition. Many of the laws contained an unsatisfactory definition of the practice of medicine, while in many others the definition is so long and complicated that it cannot be understood without the greatest study and care. As an illustration of such a definition I quote from the Ohio law as follows:

"Any person shall be regarded as practicing medicine or surgery or midwifery within

the meaning of this act, who shall use the words or letters 'Dr.' 'Doctor,' 'Professor,' 'M. D.,' 'M. B.,' or any other title, in connection with his name, which in any way represents him as engaged in the practice of medicine or surgery or midwifery, in any of its branches, or who shall prescribe, or who shall recommend for a fee for like use any drug or medicine, appliance, application, operation or treatment, of whatever nature, for the cure or relief of any wound, fracture or bodily injury, infirmity or disease. The use of any of the above mentioned words or letters, or titles in such connection, and under such circumstances as to induce the belief that the person who uses them is engaged in the practice of medicine or surgery or midwifery in any of its branches, shall be deemed and accepted as prima facie proof on an intent on the part of such person to represent himself as engaged in the practice of medicine or surgery or midwifery, provided, however, that nothing in this act shall be construed to prohibit service in the case of emergency, or the domestic administration of family remedies; and this act shall not apply to any commissioned medical officer of the United States army, navy or marine hospital service, in the discharge of his professional duties, not to any legally qualified dentist when engaged exclusively in the practice of dentistry, nor to any physician or surgeon from another state or territory who is a legal practitioner of medicine or surgery in the state or territory in which he resides, when in actual consultation with a legal practitioner of this state, nor to any physician or surgeon residing on the border of a neighboring state, and duly authorized under the laws thereof to practice medicine or surgery therein, whose practice extends into the limits of this state; providing, that such practitioner shall not open an office or appoint a place to meet patients or receive calls within the limits of this state. Nor to any osteopath who holds a diploma from a legally chartered and regularly conducted school of osteopathy in good standing as such, wherein the course of instruction requires at least four terms of (5) five months each in four separate years. Providing that



the said osteopath shall pass an examination satisfactory to the state board of medical registration and examination in the following subjects, anatomy, physiology, chemistry, physicial diagnosis. Providing that said osteopath shall not be granted the privilege of administering drugs nor of performing major or operative surgery."

The definition as contained in the California law is almost as long and complicated. The New York law does not contain a satisfactory definition of the practice of medicine, and my understanding is that the attempt, which has been made to remedy the defect, has failed.

It has seemed to me, in reading over all the definitions of the practice of medicine contained in the laws of the various states, that while most of them are much longer and more complicated than that in the Illinois law; they are, at the same time, less comprehensive and give our courts less opportunity for a proper and reasonable interpretation.

I believe our definition would be strengthened if it said, "any person shall be regarded as practicing medicine, within the meaning of this act, *who for compensation, gain or reward, received or expected*, shall treat or profess to treat, etc., etc." However, I take it for granted that the learned judge who framed the definition must have fully considered these points, and have eliminated them as unnecessary.

Certainly it has never been the intention of the State Board, or of the State Society, to undertake the prohibition of the domestic administration of family remedies, or to prevent one from applying a bit of court-plaster to the cut finger of a relative or friend. I feel sure that no court could sustain for a moment such a proposition, nor should they do so.

It has been the policy of the legislative committee to retain everything of the present medical practice act which is valuable. Our principal object is to secure the establishment of a proper board of examiners separate and distinct from the state board of health. This board is not desired because the state board of health has not been efficient in enforcing the medical practice act, but be-

cause, as our State has increased in population and wealth, the demands upon the state board of health have increased so enormously and have become so far reaching, that it is no longer just to them to continue the work of regulating the practice of medicine.

The committee on medical legislation is pleased with the kind words contained in the letter of Dr. Blair, and consider his criticism of especial value as coming from an attorney, who is also a graduate in medicine and a lecturer on "medical jurisprudence."

It is the desire of the committee to secure the best law possible; at the same time we wish to have one which is simple, plain, and comprehensive, and to retain every good feature of the present law.

Respectfully,

Carl E. Black,

Chairman, Legislative Committee.

## State Items.

### IMPORTANT MEDICAL COLONY.

The chief executive officers of three of the largest, most powerful and influential medical organizations in the world have offices on one corner of Chicago's down town district.

Within shouting distance of each other are the presidents of the American Medical Association, the Illinois Medical Association, and the Chicago Medical Association. Dr. Frank Billings, who is at the head of the national body, and Dr. M. L. Harris, president of the state organization, have offices in the Reliance building, 100 State street, while Dr. W. A. Evans is directly across the street in the Columbus Memorial building. Thus the hand of power of these associations of medical men is centered about the busy, hustling corner where Washington street intersects State street.

This unusual condition of affairs was brought about by the recent election of Dr. Billings and Dr. Harris, and for another year at least the two presidents will direct the movements of their respective associations

from within the colony of physicians having offices in State street, between Lake and Madison streets. The fact that Chicago can lay claim to the seat of power of these strong associations is significant for the reason that the organizations of which these local physicians are the head are the greatest in their respective fields in the world.

The American Medical Association embraces in its members practically all of the prominent physicians and surgeons of the country, and in the matter of power and extent of scope is not equaled in any country in the world. Its members number 25,000, it is worth \$100,000, publishes its own journal, which is devoted to the profession, and superintends the enactment of laws considered beneficial to members. The Illinois Medical Association, with a membership of 4,000, is the largest state organization in the world, and the Chicago Medical Society, with 1,050 members, all of them physicians in Cook county, occupies a similar position in comparison with individual towns, cities and counties. The assets of the Chicago Association amount to \$10,000, and there are but six states which can lay claim to larger organizations. These are Illinois, New York, Pennsylvania, Indiana, Ohio and Alabama.

Each of the organizations presided over by Chicago physicians is a counterpart of the other, with the exception that the scope of operations is enlarged in each case to cover the field involved. But the plan of operations is to all intent the same. A plan was recently inaugurated whereby the county, state, and national bodies are to be allied by making it compulsory upon an applicant for admission to the American Association that he shall first have joined his county and state organizations. Likewise membership in both of these makes a physician a member of the major association.—Tribune.

#### OBITUARY.

O. A. Dean, Campbell Hill, President of the Southern Illinois Medical Association, and by virtue of that office Vice President of the State Society, died at his home Aug. 2, 1902. Death was caused by typhoid

fever. He was 48 years of age and loved and respected by everybody in Jackson county. He leaves a wife and three daughters. Letters informing the Journal of his death and of regret have been received from J. A. Helm, Vice President, who succeeds Dr. Dean as President, and from O. B. Ormsby, Secretary.

#### MORE TROUBLE FOR THE MASTER SPECIALIST.

Several months ago we had occasion to note that Dr. Guy W. O. Mitchner, sometime an ordinary practitioner in Kansas, Edgar county, later located in St. Louis and advertising himself as the master specialist of America, had been rudely stopped in his meteoric career by the sheriff of Montgomery county and required to spend a season in jail at Hillsboro. The enclosed clipping from the Mattoon Journal would indicate that he is not yet out of trouble:

#### SPECIALIST IN HOC.

**He Is Charged With a Penchant For Altering Checks.**

Dr. Guy Mitchner, the "World's Famous Specialist" of St. Louis, arrived in the city at three o'clock this afternoon to appear before Judge Henley and give bond.

Mitchner was indicted some time ago in the city court on a charge of securing the signature of Israel Herber to two checks, aggregating \$110, on false representations. He contracted to treat Herber for certain maladies and failed to comply with the terms.

The doctor will allege, it is said, that he would have carried out his part of the agreement had not circumstances over which he had no control intervened. One of these pieces of misfortune was confinement in the Montgomery county jail at Hillsboro for ninety days upon conviction of having altered certain checks. These checks were given by patients and the doctor changed the numbers on them, an operation which the aforesaid patients seriously resented when the checks turned up for payment later on.

The festive physician changed his base to Arkansas, but was looked up by a hard-hearted deputy sheriff and rudely haled back to Illinois.

#### THE COUNTRY DOCTOR'S PRIVATE HOSPITAL; LETTER OF ADVICE TO A FRIEND.

By J. C. Sexton, M. D., of Rushville, Ind.

Dear Doctor—The country doctor's private hospital is a theme that is very near to

the heart and very dear to the pocket of the owner. It may or may not deceive its looks, but it will deceive its name, for, whatever else it is, it certainly is not private. It is private in nothing but the expense account. The public knows all about you, either through the columns of the busybody countyseat newspaper, gossiping nurses, or, more often from the delineation of details to the public by relatives and friends of the so-called private patient. The most obscure individual in your county has only to become a patient in your private hospital to immediately become a public character. Nothing is any longer private about him. His name is on every tongue, and daily bulletins are expected. He can run for office immediately upon his discharge, for, rest assured, everybody knows who he is. There is no end of advertising done for you "free gratis." A noted infants' food is advertised by its loving friends, but a country doctor's private hospital is advertised for the most part by its enemies. If the gossip ceases for a little, you need only to have a death in your house, when it all begins over again and is told and retold until the little children will hurry by your place with pale lips and bated breath, and in the imagination of the fanciful they see over your portal, in red letters, writ large, "All hope abandon, ye who enter here." Some of the advertising also comes from your colleagues, who will ask your neighbor if there is anything doing up at the slaughter-house this morning, and two days later will come in and ask you to divide a fee with them.

To give an illustration of the esteem in which you are held by envious competitors is like the old lawyer and rich man down at Lawrenceburg. He owned a sawmill and a bank and a good farm, and when my uncle asked him how he was getting on, he said, "Fairly well." He said he had a good law business and a good farm, and between the two he managed to keep the damned old mill a-running. One of my doctor friends visiting a neighboring city, was asked how S— was getting along in his hospital. He said S— had a good family practice, a rich old daddy-in-law, who was liberal with him, and his wife took in boarders, and between them all he did keep the hospital going. Many there are who think the country doctor's private hospital a valuable addition to the town and worthy of support, but no one in particular wants to be the one to support it. Some there are who think, or seem to think, a hospital is run for glory, for they will even beat a nursing bill. Some people think a private hospital is a place where the sick or injured will find care and comfort, but if you charge a good fee for your services they will say they could have done better at a two-dollar hotel. Some will say your work is good and your nurses self-sacrificing, while others will say your place is run for revenue only. Some will bless you as a philanthropist, while others will say of you, as Fra Elbertus said of the lawyers, that you have only two objects in life—grand and petit larceny.

Having a private hospital in the country,

you will find that your clientele will be for the most part the emergency cases that are too sick or too badly injured to go to the cities, or the impecunious that are too poor to get away. If you are full of that most blessed of gifts to a medical man, scientific enthusiasm, and your greatest desire is to do better work, then a private hospital, with every detail perfect, will be a success to you and will pay you in the satisfaction you will get out of it. If you desire to use it as a means of advertisement, it will surely succeed, for most certainly it will be well advertised. If you think to make of it a source of revenue and large earnings on your investment, you will just as certainly fail in the attainment of your ends. You can without question earn more money in the mileage, riding back and forth to and from their houses in the country, than you can in the fees for the board and nursing.

All doctors know the demands that are made upon their time, and by putting some of the cases in your hospital you will have better command of your time, but you also lessen your earnings. If you desire less work and better work, less riding and more time for study, writing and experiment, more accurate scientific observation of your cases and less money, then a private hospital will be a success to you.

Owning a private hospital in the country is like owning race horses. They may win you a nice purse off and on, but they keep at the hay all the time; and you may get a good fee now and then, but the rubbers and tenders, the blankets and brushes, the harness and traps must all be there all the time and in order all the time. It is doubtful if there is a private hospital in any town in this country that pays any interest on the investment if the doctor who owns it will take out his fees. But, on the other hand, there is no manner of doubt but the very best work is only to be done under the best and most advantageous surroundings.

No one can please all the people all the time any more than he can fool them all the time, as Mr. Lincoln said, and you will not be able to command all the work in your consulting district, even of those who need hospital treatment. You will find many a time the words of an old Irishman I knew in my boyhood come home to you. I asked him why he had never married. He said: "Well, son, I'll tell ye. Them as is as I want I can't get, and them as is as I can get I don't want." And, though you may not want some, you will, and pretty nearly must, take them, for if you deny them desirable relatives will deny you. This is true every day in the year, as you have no doubt found out long ago in your country work, for there isn't a doctor two years in the buggy that doesn't know it. This will give you an outline of some of the pleasures you will have, and so think several times before going into it, for it is as bad as the opium habit. Once you have it, you will find it very hard to give up. The satisfaction of doing good work and doing it well, of having things your own way, of making progress and winning success with-



out being hampered by household attendants or a fool board of lady managers or a lot of bull-headed spenders of some philanthropist's money is something worth living for and too good to give up. The comparison is like the fellow who said he had a little boy at home and would not take ten thousand dollars for him, but would not give ten cents for another. So, if I was without mine, and never had had one, and never knew the comfort and satisfaction of treating diseases and doing surgical work according to my own ideas, I would not give ten cents for one. But, having what I have—poor as it is—and doing the work I do—bad as it may be—I would not part with it for all it has cost and is costing me. Then there is another thing that will be the greatest pleasure of all to you, and perhaps I should have mentioned it first, instead of putting it at the end of my letter, and that is the pleasure you will get in the confidence your medical friends place in you. The doctor who brings his neighbor and says: "I will be responsible for this man's work;" the doctor who brings his own little girl to have tubercular glands enucleated; the doctor who brings his son to have an offending appendix removed; the doctor who brings his wife to have a roaming kidney placed under control, or the doctor who comes himself with prostatic disease or deep abscess—these are the cases that make it worth while, for these are the people that understand the responsibility and appreciate the value of your services.

A doctor has two reputations to make—the one he makes among the laity, whence comes his bread and butter, and the one he makes among his medical associates, whence comes the satisfaction of having his integrity and ability recognized. And it is this latter kind of reputation you must gain and this kind of recognition and support and backing you must have, or your private hospital will fail, and fail utterly, and you will be classed with those who builded their houses upon the sands, and people will say of you, as of many another "sucker;" "The fool and his money soon parted!"—Indiana Medical Journal.

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**SCHEDULE OF MINIMUM REQUIREMENTS  
FOR MEDICAL COLLEGES  
TO BE DETERMINED IN "GOOD  
STANDING."**

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Adopted by the Illinois State Board of Health,  
July 8, 1902.

In force January 1, 1903.

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**Conditions of Admission to Lecture Courses.**

1st. Creditable certificates of good moral character signed by two physicians of good standing in the state in which the applicant last resided.

2d. As evidence of preliminary education, as a minimum requirement, a diploma or cer-

tificate of graduation from a High School; or a certificate signed by a principal of a regularly organized High school, or by the Examiner of the Faculty of a recognized literary or scientific College or University, or by the State Superintendent of Public Instruction, or Superintendent of Public Schools, of having successfully passed an examination in all the several branches usually embraced in the curriculum of a four years' High School Course. The examination shall not be conducted by any member of the Faculty of the Medical College.

The Illinois State Board of Health will require each applicant for a State certificate to present the documentary evidence of his preliminary education, together with his medical diploma when taking the examination of the Board.

The conditions above set forth will govern in the case of all persons admitted to the Freshman Class of a College, on or after January 1, 1903.

**Advanced Standing.**

Applicants holding the degree of A. B. or B. S. or an equivalent degree from a regularly established college of Arts or Science, which requires an attendance of three or more years as an essential to graduation, may be given credit for work done in the branches of the medical curriculum of the first year and may be advanced to the Sophomore Year of a four years' medical course, on condition that they comply with the Entrance Requirements of this Board and that they subsequently complete the work of the Freshman Year and that the courses already taken shall not be below the standard required by this Board.

The same advanced standing may be allowed to applicants presenting a Degree in Dental Surgery from a recognized College of Dentistry, or documentary evidence of having completed in a reputable University, College of Arts or Science, the major part of the work usually embraced in the curriculum of the Freshman Course of a recognized Medical School, provided, first, that all such students shall have complied with the Entrance Requirements of the Illinois State Board of Health; second, that they shall subsequently complete the work of the Freshman Year, and third, that the work of the said Freshman Year shall not be below the standard of work required by this Board.

Advanced standing to the Senior Year may be granted to non-graduate licentiates of this and of other Boards.

No such advanced standing shall be allowed until after the applicant shall have either received his liberal degree or performed work as indicated above, and not until three months after the completion of said work.

These requirements for advanced standing will govern in the case of all persons admitted to the Sophomore Class of a Medical College, on or after January 1, 1903, and can be made operative prior to that time.

Graduates of Medical Colleges recognized at any time by the Illinois State Board of

Health may be admitted to any class without examination.

Students of said colleges who possess certificates of attention and of successful examinations, can enter without examination the class immediately following that previously attended. The student shall be required to pass an examination in all branches in which he has been found deficient. Students who have attended one or more full courses in colleges not fully recognized by this Board, may be granted advanced standing in accordance with such attendance, on complying with the Entrance Requirements set forth in the Conditions of Admission to Lecture Courses, and passing all examinations and performing all laboratory work of the classes below that which they enter.

Graduates or students of colleges to which no recognition is given by the Illinois State Board of Health can be granted no advanced standing whatever.

#### **Length, Number, and Character of Courses of Lectures.**

The college shall have a four years' course of instruction, consisting of four terms, extending over a period of four calendar years, and the minimum time between the commencement of the work of the Freshman Year and the ending of the work of the Senior Year, on which all students are required to be in attendance, shall be not less than forty months. No two terms begun after January 1, 1903, shall commence and end within any consecutive sixteen months.

The time occupied in each regular term begun or after January 1, 1903, shall not be less than seven months or thirty weeks, and each such term shall consist of not less than eight hundred hours of work.

The branches of medicine to be included in the course of instruction shall be at least as follows:

- (1) Anatomy.
- (2) Physiology.
- (3) Chemistry.
- (4) Materia Medica and Therapeutics.
- (5) Theory and Practice of Medicine.
- (6) Pathology and Bacteriology.
- (7) Surgery.
- (8) Obstetrics.
- (9) Gynecology.
- (10) Hygiene.
- (11) Medical Jurisprudence.
- (12) Ophthalmology, Otology, Dermatology, Orthopedic Surgery, Neurology.

Two questions in each and rated as one branch.

#### **Attendance and Examinations or Quizzes.**

1. Regular attendance during the entire lecture courses shall be required, allowance being made only for absences occasioned by the sickness of the student or his immediate family, such absence not to exceed 20 per centum of the course.

#### **Dissections, Clinics, and Hospital Attendance.**

1. Each student must have dissected at least the lateral half of a human cadaver.

2. He shall have at least two terms of clinical and hospital instruction.

#### **Instruction.**

The college must have a sufficient and competent corps of instructors, and facilities for teaching, dissections, ambulatory and hospital clinics which obtain in the majority of medical colleges in the United States.

#### **Graduation.**

No student shall be graduated by any medical college in good standing with the Illinois State Board of Health who has not completed four full terms or lectures as presented by the rules of the said Board (certain persons to whom advanced standing is allowed excepted) and has complied with the requirements of the said College, as set forth in the published announcement of the college, and has completed in the college by which his diploma is granted, a continuous course of lectures in the Senior Year of at least seven months in duration.

#### **Further Conditions of Recognition of Medical Colleges.**

**Rule I.** Only regularly conducted and legally chartered medical colleges which conform to the conditions of admission to lecture courses, the course and period of study, the number, character and length of lecture terms, the duration of attendance on hospital and clinical instruction, as set forth in the Schedule of Minimum Requirements adopted by the Illinois State Board of Health, and the other requirements of a medical education which obtain as the practice of a majority of the established medical colleges in the United States shall be considered Medical Institutions in good standing according to the purpose of the Act to Regulate the Practice of Medicine in the State of Illinois, approved April 24, 1899.

**Rule II.** No medical college can be held to be in good standing until it has established its claim to such standing by an active existence of not less than four years, and then only on compliance with the terms of Rule I. Provided, that colleges which after a personal investigation made by a committee of the Board, are shown to comply with the Schedule of Minimum Requirements, and to possess a sufficient and competent corps of instructors, all legally qualified physicians, and the necessary facilities for teaching, may, at the discretion of the Board, be granted full recognition during the first year of existence.

#### **Note.**

All colleges in "good standing" with the Illinois State Board of Health, will be required to conform to the Schedule of Minimum Requirements in all regular courses commencing on or after January 1, 1903.

Advanced standing to the Sophomores, Junior or Senior Classes may be granted to students who have completed courses in the Freshman, Sophomore, or Junior Years, prior to June 30, 1903, in accordance with the Schedule of Minimum Requirements heretofore adopted by the Illinois State Board of Health.

All rules and regulations governing medical colleges which have been heretofore adopted by the Illinois State Board of Health, will stand repealed on December 31st, 1902.

### Local Societies.

The Morgan County Medical Society met in regular session on Thursday, June 12th, 1902.

Dr. Pitner presided in the absence of the president and vice president.

The minutes of the May meeting were approved as printed.

The appointments for the July meeting were announced as per card as follows: Emergency Surgery—Drs. Black, Bowe, Adams and Hairgrove. Leaders—Drs. Smith, of Roodhouse, and Franken.

The following resolution was introduced by the secretary and properly seconded:

Whereas, The secretary of this Society is not a shorthand reporter; therefore be it

Resolved, That any member (desiring the publication of any reports of cases or discussion of any paper or papers read before this Society) is requested to hand an abstract of the same to the secretary within five (5) days after the date of the meeting and the abstract will be published as furnished, otherwise the member will be announced as having reported a case or cases or discussing such and such a paper.

The motion prevailed and the resolution is a standing order of the Society.

Under the head of reports of cases Dr. Cole reported some cases of fractures in elderly people.

Dr. Maness reported a number of cases of dropsy with liver involvement and the treatment.

Dr. H. C. Campbell reported a case of gastro-intestinal disease with spasms with a temperature of 107 4-5 degrees.

Dr. C. E. Burkholder read a paper on "Gastro-Intestinal Diseases of Children." Drs. Hairgrove, Cole, Pitner and Wakely discussed the paper.

Dr. Campbell read a paper on the "Dietetics of Gastro-Intestinal Diseases of Children." This paper was discussed by Drs. G. Edwin Baxter, Mr. George Stacey, Dr. Campbell, Dr. Wakely, Dr. Pitner and Dr. Burkholder.

Members present—Dr. Maness, of Nortonville; Drs. Adams, Geo. Edwin Baxter, Burkholder, Campbell, Hairgrove, Pitner and Wakely, of Jacksonville. Mr. George Stacey was present as a visitor.

On motion the Society adjourned.

T. A. Wakely. Official Reporter.

The Pulaski County Medical Society met at Mound City, Tuesday, July 1st, 1902, with the following present: M. L. Winstead, L. F. Robinson, J. B. Mathis, Jr., B. F. Crabtree, B. F. Brown, J. F. Haragan, J. B. Mathis, Sr., Hall Whiteaker, C. B. Powell, W. J. Whiteaker, A. W. Tarr, C. J. Boswell

The subject of fee bill was discussed at length, it being the opinion of the majority of members present, that a uniform fee bill for the entire county was impracticable.

On motion the president appointed J. F.

Haragan, J. B. Mathis, Sr. and C. J. Boswell as a committee to draw suitable resolutions on the death of James H. Crain.

After adjournment for dinner the following papers were read:

**Intestinal Diseases of Children** during summer months and their treatment, J. B. Mathis, Jr.

His treatment consisted in keeping child cool as possible by dressing lightly and frequent bathing in cool water. Clean out alimentary canal with 1.12 gr. doses of calomel followed by castor oil. Fever controlled by small doses of tincture aconite. As an intestinal antiseptic combination of zinc sulphocarbolate salol, calomel and bismuth sub-galate. Restricted diet with opiates when necessary to control the pain.

The paper was discussed by Drs. Haragan, Brown, Mathis, Sr., Winstead, Robinson, Hall Whiteaker, A. W. Tarr, and closed by the author.

B. F. Brown gave a very interesting talk on the present epidemic of smallpox and its treatment. The doctor stated that the present epidemic lacked several of the prominent symptoms which characterized the former epidemics of smallpox, and was of the opinion that if genuine it was a very much modified form. The subject was discussed by Drs. Robinson, Powell and Mathis.

**Treatment of Fracture of the Femur** by the general practitioner, by W. J. Whiteaker, was an able effort and elicited spirited discussion by all present.

**Appendicitis; How to Cure It Without Operation**, was the title of a very interesting paper by M. L. Winstead. The doctor claimed that there was a reaction toward conservative or medicinal treatment of appendicitis on the part of the majority of the medical profession and that a great many abdominal cavities were invaded by the surgeon's knife when no appendicitis was present, due either to mistaken diagnosis or to mania on the part of some members of the profession to use the knife.

His treatment consisted in free movement of the bowels by small doses of calomel followed by saline and hot antiseptic injections into the bowels. Control pain with morphine. Apply over diseased region cloths saturated with turpentine, camphor and lard applied as hot as could be borne. Fever to be controlled by some of the coal tar products.

The paper was discussed by Drs. Hall Whiteaker, Robinson, Mathis, Sr., Boswell, Haragan, Brown and closed by the author.

There being no further business the society then adjourned.

Charles J. Boswell, Official Reporter.

The St. Clair County Medical Society held its regular quarterly meeting at Priesters' Park on June 5th, A. B. Gunn, vice-president, in the chair.

Members present were B. Portuondo, recording secretary; C. W. Lillie, corresponding secretary; A. Hansing, treasurer, and Julius Kohl, C. G. Rayhill, E. M. Irwin, A. M. Kohl, W. West, Jr., H. Hanson, H. G. Hertel, John C. Gunn, W. S. Wiatt, C. Rembe, C. L. Starkel, E. P. Raab, and F. E. Auten, of Belleville;



C. F. Whitmer and G. C. Adams, of East St. Louis; J. A. James-James, of St. Louis, visitors. Minutes of last meeting read and approved.

Bills amounting to \$9.50 presented and ordered paid.

A motion to notify all delinquent members of the amount due, and upon their refusal to pay, to drop their names from the roll book was adopted.

C. F. Whitmer, of East St. Louis, was proposed for membership, and on motion the rule was suspended, and he was elected.

On motion of B. Portuondo a committee of three, Portuondo, Lillie and Starkel, were appointed to draft resolutions upon the death of A. C. Corr.

The committee presented the following tribute, which was adopted:

#### Death of Alexander C. Corr.

This society realizes that in the death of Alexander C. Corr it has lost one of its most capable and active members; the State a useful citizen.

We feel that the highest tribute to his memory which words can express will be found in the one simple thought that he was a true man, just and upright in his dealings with his fellow-men.

The cause of medical society advancement has lost in him one of its most earnest advocates.

No man in Southern Illinois contributed more to the perfection of medical laws than did he.

To his bereaved companion, also an honored member of the medical profession, we extend our profound sympathy and express a hope that her future may prove far brighter than it at present appears.

C. Rembe presented photographs of a child five months old showing a deep indentation in left parietal region.

The Rock Island County Medical Association met June 27th at the parlors of the Harper House, Rock Island. J. F. Myers, President, being in the chair. Dr. Myers as delegate to the meeting of the Illinois State Medical Society at Quincy, made his report, and his report was voted to be accepted and placed on record.

The president reported that the secretary of the Rock Island Medical Society had refused to furnish him with the names of its members. However, such members as far as known were collectively and individually unanimously elected to membership in the association.

The motion prevailed that the secretary notify each new elected member of his election to membership without fee.

After disposal of a short though interesting program the semi-annual election of officers was held resulting as follows: J. W. Morgan, president; Peter Eckhardt, first vice-president; C. F. Foster, second vice-president; J. F. Myers, secretary; Louis Astrom, treasurer.

Before taking the chair Dr. Morgan made an eloquent plea for better feeling among the physicians in Rock Island County, urging that they all unite on one basis of ethical and professional honesty and that all personal enmities be laid aside.

A. D. West, Official Reporter.

The Rock Island County Medical Association met at Hotel Windsor, Moline, Ill., on July 25th, with President J. W. Morgan presiding.

The motion prevailed that the president and secretary should ascertain under what conditions physicians holding homeopathic diplomas could be received as members so as to be in harmony with the code of ethics established by the Illinois State Medical Society.

J. J. Huntington read a paper on **The relation of nasal disease to trifacial neuralgia**. He showed by citing a number of cases the necessity of nasal examination in all cases of trigeminal neuralgia of obscure etiology.

Dr. Ostrom differed from Dr. Huntington in that he had found that spurs or other nasal lesions but seldom gave rise to neuralgia.

The use of castor oil internally in tic d'oroux was also discussed.

G. G. Craig, Jr., read a paper on **modern methods of diagnosis**. He lay particular stress on the use of the microscope as one of the most modern and useful instruments of diagnosis.

He believed that the most promising field, for medical research was the examination of the blood. After a free discussion of this valuable paper the association adjourned.

A. D. West, Official Reporter.

The Richland County Medical Society was organized July 11, 1902, at Olney. The following are members: A. L. Ziliak, president, Olney; E. Rowland, vice president, Olney; M. E. Poland, secretary, Calhoun; J. W. Spain, treasurer, Olney; W. A. Thompson, Olney; D. W. Bower, Calhoun; W. E. Fritschle, Olney; C. E. Martin, Claremont; G. T. Weber, Olney; J. P. Soliss, Olney; M. D. Foster, Olney; H. T. Watkins, Olney. Meetings are held the last Saturday in each month.

M. E. Poland, Official Reporter.

The Green County Medical Society was organized at White Hall on June 27th and constitution and by-laws adopted and permanent officers elected at Carrollton on July 18th.

#### Officers.

President, F. A. Clement.....Greenfield  
1st Vice President, H. W. Hand....White Hall  
2d Vice President, J. A. Cranus..Wrightsville  
Sec. and Treas., H. A. Chapin.....White Hall

#### Censors.

H. W. Chapman.....White Hall  
E. H. Higbee.....Roodhouse  
H. Connose.....Greenfield  
Meeting Second Fridays in September, December and June.

#### Members.

A. Bowman, White Hall.  
J. T. Coon, Carrollton.  
J. E. Waters, Athensville.  
Geo. W. Burns, White Hall.  
E. S. Gooch, Carrollton.  
Jas. Squin, Carrollton.  
H. W. Chapman, White Hall.  
G. W. Ross, Carrollton.  
J. B. Hays, Carrollton.  
Howard Burns, Carrollton.  
T. H. Hall, Carrollton.

J. W. Adams, Walkerville.  
 E. E. Jouett, Woody.  
 J. A. Cravens, Wrightsville.  
 A. W. Foreman, White Hall.  
 H. W. Hand, White Hall.  
 J. W. Redwine, White Hall.  
 F. A. Clement, Greenfield.  
 H. Converse, Greenfield.  
 E. H. Higbee, Roodhouse.  
 H. A. Chapin, White Hall.

The Wabash County Medical Society met July 29, 1902, with a good attendance. G. C. Kingsbury read a paper upon the "**Medicinal Uses of Alcohol.**" He took the ground that alcohol was neither a food nor a stimulant, but a narcotic poison and that it had no place in medicine. The paper was discussed by many of those present, the majority agreeing with him, others arguing that its field of usefulness was limited and becoming less so each year, but were not yet willing to abandon its use altogether.

J. B. Maxwell made a report of the American Medical Association meeting, which he attended at Saratoga Springs, N. Y.

The following officers were elected for the ensuing year: J. C. Utter, president; J. Schmick, vice president; G. C. Kingsbury, secretary, and J. B. Maxwell, treasurer.

Society adjourned to meet in October.

J. B. Maxwell, Official Reporter.

The Morgan County Medical Society met in regular session on Thursday, July 10, 1902, in its rooms in the Hockenhull building.

P. C. Thompson, the president, called the meeting to order.

Members present: G. V. Black, of Chicago; G. W. Miller, of Woodson, and Adams, C. E. Black, Burkholder, Cole, Norbury, Pitner, Thompson and Wakely, of Jacksonville. Visitor, Mr. George Stacey, of Jacksonville.

The president announced the program for August 14, 1902, as per card—"Malaria," Drs. Cole, Boone and Crane. Leaders, Drs. Norbury, Vertrees and Neville.

The secretary announced the fact that three copies of the Journal for the Society for the years 1899, 1900 and 1901 had been bound and were now in the possession of the Society.

The application of R. H. Garm, of Beardstown, was received in due form and placed on file.

G. W. Miller reported several cases of typhoid fever, and also a very interesting case of miscarriage with a large quantity of hydatids.

C. E. Black spoke of a previously reported case of hydatidiform mole, and also reported a case of nephritis in which he performed Edelbohl's operation on the kidneys for Bright's disease.

F. P. Norbury reported two cases of valvular disease of the heart, both of which were fatal.

G. V. Black asked about the desirability of giving anaesthetics in cases of valvular lesion of the heart.

Dr. Norbury answered the question, giving the latest views on this point.

C. E. Black read a paper on "**Emergency Surgery.**"

The paper was discussed by the following members: Drs. Norbury, Cole, G. V. Black, Pitner, Thompson and Wakely. C. E. Black closed the discussion and answered inquiries in regard to the card system of records.

On motion the Society adjourned.

T. A. Wakely, Official Reporter.

The Crawford County Medical Society at the July meeting elected J. B. Cato of Hutsonville, president, and E. M. Cooley, Oblong, secretary.

A banquet was given to S. D. Meserve at Robinson, August 8, the pioneer physician and surgeon of this section, by the members of this society, the occasion being the 84th anniversary of the doctor's birth. Covers were laid for thirty guests, all being county doctors. Besides discussing the elaborate feast, there were a number of toasts which partook of the jargon of the profession. A handsome Morris chair was presented the doctor at the close of the banquet.

Dr. Meserve is a native of New Hampshire and came west at an early day. He tarried long enough in Cincinnati to attend a course in medical lectures, something then not regarded as necessary with those who, as the doctor had, had "read medicine." Being then equipped with a "degree," and seeing the possibilities of practice in the Wabash valley, he located in this county about the middle of the forties.

He soon attained a large practice, and by Yankee thrift and foresight amassed a handsome fortune. His success in the practice when this section was regarded as one of perpetual "fever and ague" made him popular as a physician, and he has long been looked up to by the younger members, and in fact, all the profession, as the Nestor of the medical profession in the county, and as such they delight to honor him.

The DeWitt County Medical Society convened in the county court room in Clinton, Ill., July 15, 1902, at 1 o'clock P. M., A. E. Campbell in the chair. Soon after the society was called to order Dr. McMackin, vice president, occupied the chair, while Dr. Campbell made remarks relative to the hospital at Philadelphia, where he attended a post-graduate course the past two months. Dr. Campbell exhibited a diagram of the different apartments of the hospital, and showed conclusively the advantages of attending a course where every department was so amply provided for, and spoke highly of the surgical and bacteriological department and the facilities afforded by them all. He also stated that the anaesthetic used was ether, which remark gave rise to quite a discussion among the doctors in regard to the safety of the anaesthetics. Some had given chloroform in every surgical case and never experienced any serious results.

J. M. Wilcox then proceeded to speak on the new constitution established by the State Medical Society, and the many valuable pa-



pers read at the meeting, which were useful and instructive. He then spoke of the necessity of a hospital in Clinton, and he thought the railroad company would perhaps contribute their mite, as 'twould be greatly to their advantage. He also said that he would contribute of his means towards the establishment as he fully realized the utility of such an institution, and that he would equip and maintain a surgical ward in same.

On motion each member present was requested to act as a committee of one to secure donations for said hospital and report at next meeting.

On motion the society adjourned to meet the second Tuesday in October.

J. H. Tyler, Official Reporter.

The JoDaviess County Medical Society held its quarterly meeting at the Country Club House, Galena, Ill., July 31, 1902.

The day was a beautiful one and the well-arranged Club House with its beautiful grounds was all open to the doctors and their wives and daughters who accompanied them.

At about 10 A. M. the first hack load was landed at this summer resort, and by 12 o'clock about 60 bright, cheerful faces greeted each other, all glad to meet, and the petty rivalry that oftentimes exists among the medical fraternity was a minus quantity. In fact these meetings have wiped all this away. The Harle orchestra was arranged on the veranda and filled the air with music. Various sports were taken up, bowling chiefly, of which some of the ladies rapidly acquired a proficiency.

At 11:30 the president, H. T. Godfrey, called the doctors to the meeting hall, while the ladies continued the sports. The minutes of the previous meeting were read and approved. And upon roll call the largest number in the history of the society responded. Those present—Godfrey, Stafford, Miller, Gunn, Bench, Egan, Smith, I. C., Hutton, Smith, W. A., Eade, Lewis, Smith, D. G., Bucknam, Phillips, Kreider, Weirich, Grassan, Bair, Wright, with J. W. Henstus of Dubuque, J. C. Blair, Hazel Green, and W. E. Clay, Pearl City, as visitors.

The committee on the formation of the Medical Library Association reported no success, and after some debating the committee was discharged and the project dropped.

The application of Allen Staples of Dubuque, Ia., was voted on and elected to membership.

The name of J. C. Blair of Hazel Green, Wis., was proposed for membership.

At this point Dr. Godfrey reported a case of Obstetrics. **Accidental Hemorrhage at the 8th Month**, still born child, with recovery of mother. The case runs as follows: 5th pregnancy, all previous ones normal, good health all along, went to bed well, and at 11 P. M. a little child sleeping with the mother fell out of bed. The mother made a quick motion, rolling over on the abdomen to reach it, picked it up. At the time of making the exertion she felt in her abdomen what she described as a tearing pain; she then felt faint, but does not think she lost consciousness. Immediately afterwards the pain commenced, not very severe;

also noticed a slight flow, and from this time on no foetal motion was felt. The doctor was called at 6 A. M. and found a prominent, almost pendulous abdomen, contractions moderately strong. No foetal heart sounds or placental souffle could be detected. Vaginal examination revealed a slight flow of blood from os which was thick, dilated to the size of a half silver dollar, but not round, but transversely oval. After some little time the presentation was made out as vertex L. O. A. and Diagnosis. Placental separation with death of foetus, of which the husband was informed.

Pain continued naturally, patient cheerful and everything seemed to progress nicely.

By noon os was dilated to the size of a silver dollar, the head fairly engaged in the superior straight, waters unbroken, pains still moderate.

At this moment he was compelled to leave the patient for a very short time. On his return he found patient pale, faint and with an anxious expression of countenance. The nurse said she had arisen to use the vessel and became weak. The pains had increased in force and expulsive power, os dilating. Treatment—patient's head lowered and alcoholic stimulants administered, the waters ruptured and gentle pressure applied to the fundus. The oozing from the vagina ceased, pains became more frequent and stronger, the head descended and 2:30 P. M. she was delivered of a still born eight months foetus. The cord was found coiled around the neck and shoulder, making it very short. Immediately after the expulsion of the child the placenta and about a quart of clots were expelled with almost explosive force.

The uterus contracted normally. No more undue hemorrhage and labor favorably concluded.

The placenta was normal; cord centrally implanted and about the usual length. It appears as if the separation of the placenta was caused by a sudden strain on cord, shortened, as it was, by being wrapped about the neck and shoulder of foetus. The questions that arise are, Did I assume too much risk in trusting to the *vis medicatrix naturae* in so serious a condition?

Should I have immediately on making my diagnosis dilated the os and effected delivery? Should I if placed in a like position again adopt another line of practice? One thing I shall certainly do if so placed again and that will be to have normal salt solution prepared and to have a syringe ready for its use both hypodermically and in the rectum.

At the close of this the society was ushered to the dining halls by the physicians of Galena. Their wives and daughters were the hosts, while the members were their guests, and well did they perform their duty, as the tables were laden with all the stomach could desire (and some doctors have big stomachs). From the beautiful tinted lemonade down to the palatable devil's food and delicious salads and fruits of all sorts up to the frozen creams and angel's food, one may know that a party of doctors could do justice to such a spread. After dinner sports



were again taken up and later a photographer appeared and the gathering, about 60 in all, sat down to see the bird fly. At 3 P. M. the doctors were again called to the meeting hall and a paper on **A Few Facts Concerning Fees**, was read by D. G. Smith, in which the subject of fees was pictured from all sides, doing ample justice to the patient as well as the doctor.

The committee who waited on the county board of supervisors reported that no compromise could be effected.

The committee to prepare a fee bill reported and presented a schedule. After much debating and a certain amount of changes, the bill was adopted and the secretary directed to have some printed for distribution among the members, but not for publication in the local press.

The subject for discussion, **Dysentery**, was opened by C. E. Wright, followed by remarks on the subject by different members.

A. C. Phillips conducted a short clinic by presenting a patient with an injury of the arm.

A vote of thanks was voted the Country Club for their hospitality and the ladies who so nobly entertained the society. After a vote to meet in Hanover on the 16th day of October, 1902, the society adjourned.

In the evening at 7 P. M. Doctor and the Misses Godfrey entertained the physicians and visitors with a musicale, which every one appreciated.

D. G. Smith, Official Reporter.

#### The Rock Island County Medical Society.

July 23, 1902.

Dr. Geo. N. Kreider, Editor of Illinois State Medical Journal, Springfield, Ill.:

Dear Doctor—In compliance with the request of Dr. M. L. Harris, president of the Illinois State Society of Chicago, who, on the invitation of the Society, appeared before it together with Dr. A. Schalek, also of Chicago, presenting two excellent and most interesting papers, that the minutes of this society be published in the Journal, although we are not recognized by the State Society as the representative society.

Very respectfully yours,

J. G. Swensson, M. D.

Tuesday evening, July 22, 1902.

The meeting was called to order at 8 P. M. at the Rock Island Club.

#### Guests Present.

M. L. Harris of Chicago, president of the Illinois State Medical Society.

A. Schalek of Rush Medical Society, Chicago.

Carl Matthey, Davenport, Ia.

Henry Matthey, Davenport, Ia.

J. H. Kulp, Davenport, Ia.

J. P. Crawford, Davenport, Ia.

H. A. Beam, Moline.

T. J. Lamping, Moline.

J. Sargent, Moline.

#### Members.

President C. Bernhardt, Rock Island.

Vice President L. D. Dunn, Moline.

Treasurer W. S. Eddy, Milan.

Secretary J. G. Swensson, Moline.

R. S. Gallagher, Rock Island.

F. H. First, Rock Island.

J. R. Hollowbush, Rock Island.

W. H. Ludewig, Rock Island.

Emily Wright, Rock Island.

J. E. Asay, Rock Island.

C. C. Carter, Rock Island.

S. B. Hall, Rock Island.

J. P. Comyges, Rock Island.

L. Ostrom, Rock Island (elected this meeting.)

G. L. Eyster, Rock Island.

W. P. Freals, Cordova.

A. G. Miller, Edgington.

W. O. Beam, Moline.

F. H. Gardner, Moline.

Martha Anderson, Moline.

A. M. Beal, Moline.

A. R. Beal, Moline.

#### Proposals for Membership.

T. J. Browning of Moline.

T. J. Lamping of Moline.

H. S. Bennett of Moline.

The board of censors having reported favorably upon the names of L. Ostrom of Rock Island and A. J. Miller of Edgington, it was moved and seconded to proceed to ballot on the names individually. The chair appointed W. O. Beam and F. H. First as tellers.

L. Ostrom, unanimously elected; A. J. Miller unanimously elected.

Final report of committee on constitution and by-laws, by the chairman, G. L. Eyster of Rock Island.

M. L. Harris of Chicago being asked for his opinion regarding constitution and by-laws, expressed himself in favor of very liberal by-laws.

Voted on by-laws by sections.

Moved by C. C. Carter and seconded that the constitution and by-laws be adopted as read, and committee be discharged. Carried.

To M. L. Harris of Chicago, president of the Illinois State Medical Society, we feel very greatly indebted for the honor he has conferred upon this, the Rock Island County Medical Society, in accepting an invitation to read a paper before the society on the evening of July 22. Especially so as this society was at the annual meeting of the State Society at Quincy legislated out of existence as far as recognition goes by the State Society.

The following program was then heard:

M. L. Harris of Chicago, president of the Illinois State Medical Society—**Tuberculosis of the Kidneys.**

A. Schalek of Rush Medical College, Chicago—**Series in the Transmission of Hereditary Lues.**

A. R. Beal, Moline—**Infantile Convulsions.**

J. R. Hollowbush of Rock Island—**Report of a Case of Ectopic Gestation.**

The members and guests of the society are cordially invited by C. Bernhardt to a social gathering at the rooms of the club after the meeting.

The most excellent as well as eminently instructive papers presented by men standing at the head of the profession in their respective specialties, as M. L. Harris, president of the Illinois State Medical Society, and

A. Schalek of Rush Medical College, Chicago, afforded this society a rare and highly appreciated treat. Dr. Harris' very exhaustive paper was made doubly interesting by three beautiful specimens of pathological kidneys submitted, illustrating the gross anatomy of the different stages in the disease and innumerable slides under the microscopes, portraying the minute pathologic anatomy.

Moved and seconded that the visiting physicians be invited to participate in the discussion of the papers. Carried.

The discussion of the papers resulted in nothing of a discussionary nature, but rather a unanimity of compliments for Drs. Harris and Schalek on their papers.

G. L. Eyster requested Dr. Harris to explain the workings and mechanism of his, the Harris Segregator, which request was heartily responded to by Dr. Harris.

Motion by A. M. Beal that owing to the lateness of the hour that the society postpone the reading of the papers by A. R. Beal and J. R. Hollowbush, and that the thanks of the society be voted M. L. Harris and A. Schalek for the excellence of their papers. Seconded and carried.

The society and guests adjourned to the Club dining room where we were banqueted by the society's beloved and highly respected president, Carl Bernhardt, in commemoration and honor of his 35th anniversary entrance into the practice of medicine. J. R. Hollowbush, toast master, "in his very short" and pleasing way, found his persuasions, heartily responded to by J. P. Crawford. L. D. Dunn. C. C. Carter, M. L. Harris, and others.

All praising and honoring C. Bernhardt and wishing him many happy returns, at an early hour we were compelled to adjourn to the station where Drs. Harris and Schalek, with many regrets, left prophesying a bright future for the Rock Island County Medical Society.

J. G. Swensson, Secretary.

**The Chicago Pathological Society** held meetings May 12 and June 9, 1902.

Ludvig Hektoen, in his presidential address, traced the history of the society which had its beginning in the West Chicago Medical Society and held its first meeting May 13, 1878, Norman Bridge being the president. In 1881 the name was changed to the Chicago Pathological Society. Later it became affiliated with the Chicago Medical Society as its Pathological Section, by which it has increased its usefulness and placed at its disposal microscopes and other apparatus required for its meetings.

Hektoen pays full tribute to the influence of Fenger, who made his first appearance March 24, 1879, and demonstrated from specimens that a case in the County Hospital treated as typhoid fever was in reality ulcerous endocarditis, which was caused by a suppurative synovitis at the bottom of a large bunion.

Fenger said this might have been the starting-point of the whole disease. As a proof that this was a blood disease the doctor exhibited under the microscope some of the ex-

udate from the heart valves, in which were myriads of micrococci. The report is signed by W. T. Belfield, secretary, whose keen appreciation of its significance has preserved this characteristic example of the thoroughness of Fenger's pathological work and of his masterly grasp of the subject even at that early day when light was just breaking over the problems involved. The investigations of the succeeding twenty-five years have added many important details to our knowledge of acute, malignant endocarditis, but the general outlines remain as sketched so succinctly by Fenger in his epitome of this case. In the same year the late Edward L. Holmes reported a case of general miliary tuberculosis with involvement of the choroid which had been examined postmortem by Fenger. Holmes adds: "I believe C. Fenger, pathologist to the Cook County Hospital, is the first physician who ever made such an autopsy in this part of the country." There were eight minute elevations in the posterior half of the choroid. In the remark of Holmes we feel a touch of the interest and astonishment with which the revelations of Fenger's postmortems were received.

Since 1894 the society has published four volumes of Transactions, which now are issued in periodical form.

## POST-OPERATIVE LEUCOCYTOSIS AND OTHER BLOOD CONDITIONS.

Herbert Maxon King.

The object of these observations was to establish a standard of leucocytosis in non-septic post-operative wound repair, a departure from which would indicate sepsis.

### Method of Observation.

Quantitative examination of the blood was made from six to twenty hours prior to operation.

A leucocyte count was made six hours after completion of operation.

A second quantitative examination, similar to the first, was made twenty-four to thirty hours after operation. A leucocyte count was made every twenty-four hours thereafter until all danger of sepsis had passed, and the leucocyte count had fallen to practically a normal number. The blood in all cases is peripheral, and obtained from the finger tip by puncture sufficiently deep to obtain specimen without compression.

In the first series of ten cases all were abdominal sections with one exception, which was amputation of the breast for malignant disease. One of the abdominal sections was also for malignant disease.

Observations extended over seventeen cases, divided into two series, in the first of which were ten cases, in the second seven. In the first series nine cases were operations upon adult women, one a young man. In the second series all were abdominal sections on adult women.

### Conclusions.

1. An increase of from 5,000 to 10,000 leucocytes per cm. following operation in from six to thirty-six or even forty-eight hours is



a normal post-operative condition, provided it be not sustained.

2. Probably the maximum leucocytosis in the majority of cases occurs within the first twelve hours after operation and is very transient.

3. The leucocytosis in the normal reparative process bears but slight relation to the pulse and temperature.

4. A leucocytosis of 10,000 or more above the individual normal sustained for more than a few hours may be looked upon with suspicion.

5. The apparent increase in number of erythrocytes following operation is not caused by an actual increase of red cells in the circulating blood.

## ANEURISMS OF THE HEART.

L. M. Loeb.

Patient, 26 years old, entered Cook County Hospital with symptoms of dyspnea, anasarca and blood expectoration. Onset had been very sudden. Chief findings pointed to pleurisy, a lesion about the aortic valves and marked hypertrophy of the heart. Death took place after one week. At autopsy were found (in brief) obliterative pericarditis, arteriosclerosis and two aneurisms of the heart, one in the anterior periaortic space and one at the apex. No gummata were found in spite of a history, giving suspicion of lues. The course of pathologic changes most probable appears: (1) obliterative pericarditis, hence (2) hypertrophy of the heart (nearly 1,000 grams); (3) aneurism at base, originating in sinus of Valsalva from action of high blood pressure on sclerotic aorta; this pressed upon left coronary artery, causing (4) aneurism at apex by interfering with blood supply in a part already exposed to very great blood pressure and firmly bound to the diaphragm. Each aneurism was as large as a small hen's egg and at its thinnest part distinctly translucent.

## CANCER OF THE VULVA.

Palmer Findley.

The vulva is strangely exempt from infection and malignant degeneration. In 1,147 cancers of the female genitalia Schwarz found 30 to be primary in the vulva. Wenkel tabulated the report of 54 cases in which he found 6 before the age of 40, 16 between 40 and 50, 20 between 50 and 60, and 20 over 60 years of age.

The site of predilection is the outer skin surface of the labia majora; less frequent points of invasion are the frenum, clitoris, Bartholinean glands, anterior and posterior commissure and urethral opening. The labia minora are seldom a primary site.

The lesion is characterized by superficial infiltration, by ulceration and by early involvement of the inguinal glands. The growth may be diffuse or circumscribed. The circumscribed growths rarely fail to rise above the level of the skin surface. They are commonly round or oval, the surface smooth, nodular or papillary. They may grow to the size of a man's fist. At first firm in consistency, sooner or later they disintegrate and form ulcers more or less superficial. The diffuse form may not be evident to the naked eye and is recognized

by its rigid, firm feel. Superficial ulceration is usually not long in appearing. There is nothing unusual in the appearance of the ulcer, the base is uneven, bleeding when handled and covered with a purulent, foul-smelling secretion; the margins of the ulcer are irregular, hard and elevated. In advanced cases the ulceration may extend to deep crater-like excavations with markedly infiltrated borders.

Schwarz found the inguinal glands infiltrated with cancer cells eleven times in twenty-three cases. The rate of growth is often slow. The direction to which the growth extends varies. Most commonly the extension is to the vagina and from the vagina to the rectum, bladder and pelvic connective tissue. In not a small percentage of cases the opposite labium is invaded (contact metastasis).

The microscopic characters of vulvar carcinoma differ somewhat from those of cancer of the vagina and cervix. There is an unusual tendency on the part of the epithelial projections to branch; cancer pearls are said to be relatively rare, although in the two specimens, one removed by Reuben Peterson, the other by J. Clarence Webster, I found an unusual number of cancer pearls. The extension of the cancer cells along the lymphatics give the appearance of veins of marble. Cancer of the glands of Bartholin is rare. The gland may assume the size of a man's fist, become hard, nodular, with a movable, normal-appearing overlying skin. The diagnosis without the aid of the microscope may be impossible. The lesions to be considered in making a diagnosis are the benign new formations (lipoma, fibroma) with ulcerated surface, ulcus rodens, tuberculosis, syphilis and elephantiasis. In making the diagnosis we rely upon the age of the individual, the general effect upon the system, early and superficial ulceration and involvement of the inguinal glands, and above all upon the microscopic examination of an excised piece. The prognosis is relatively good. Schwarz saw ten recoveries in twenty-three cases.

## THE HEALING OF ULCERATIVE ENDOCARDITIS.

James B. Herrick.

While recognizing that it is difficult at times to draw a sharp line separating the acute benignant (often toxic?) endocarditis from the malignant or ulcerative form, yet a fairly definite complexus of symptoms—chills, irregular fever, embolic phenomena, petechiae, anemia, bacteria in the blood, cardiac murmurs, etc.—is found to indicate a disease whose anatomical findings are shown at the autopsy to be those of the ulcerative endocarditis.

While these cases are generally fatal, recovery is possible. The argument for the proof of this is along three lines.

First, ulcerative endocarditis being in reality a septicemia, we might expect occasional recovery in this form of sepsis as in others, e. g., puerperal septicemia.

Secondly, there are numerous cases of recovery reported by clinicians. In many of these the clinical histories are complete even to the detection of bacteria in the blood. Some-



thing like forty cases have been found and the search of the literature has not been complete. I have seen one case which I regard as recovery from an acute endocarditis due to the pneumococcus, the symptoms being those of the malignant type.

Thirdly, the postmortem examination in patients dying from the mechanical effects of valvular disease induced by the preceding endocarditis, may show that repair has actually occurred either partially or completely, that the lesion was a destructive one with the ear-marks of the ulcerative form, and that the bacteria present on the valves are degenerate or dead. Valuable work in this line has been done by Harbitz of Christiania.

In ten cases he has found that the lesions correspond to those seen in other cases dying of the sepsis accompanying the endocarditis. But in the healed cases repair has been complete or farther advanced and the bacteria present (as shown by culture and inoculation), have lost their virulence. The bacteria found in this class of cases were chiefly the streptococcus and the pneumococcus. Cases due to the staphylococcus have not only run a more malignant clinical course, quite uniformly rapidly fatal, but the endocardial lesions show no tendency toward healing and the organisms are actively virulent. It is worthy of note in connection with these observations of Harbitz that, in most of the cases of reported recovery that I have found, the organism where it has been identified has been the streptococcus or the pneumococcus.

Dr. Hektoen has kindly furnished me with three specimens and the autopsy records that illustrate these points. (The specimens and drawings were exhibited.) The patients did not die from the infectious process. The lesions on the valves—in all three of the aortic—showed warty vegetations, perforations of the valves with scarred, rounded, firm edges. There was marked fibrosis and some calcification.

The following excerpt from the description in one case (No. 1,089) will serve as a type. The aortic valves are incompetent to the water test. They are deformed by irregular wart-like masses of fibrous tissue and of rather soft but not crumbling whitish tissue, in which are fine calcareous granules. The left posterior cusp shows a large circular perforation about 1 cm. in diameter; the superior margin consists of an irregularly nodular band, 4x8 mm., while the inferior is thin and perfectly smooth. In the spleen and kidneys were old healed infarcts.

If, then, recovery is a possibility, it should lead to more persistent efforts in the way of treatment and should make one a little more hopeful in the matter of prognosis. And as the clinical course and the outcome seem to vary, depending upon the micro-organism present in a given case, greater care should be exercised in determining by bacteriological examination of the blood what germ is at fault. And it is to be hoped that treatment by antitoxin or serum may in the future be more rational and make recovery, at least from the septic element, of more frequent occurrence.

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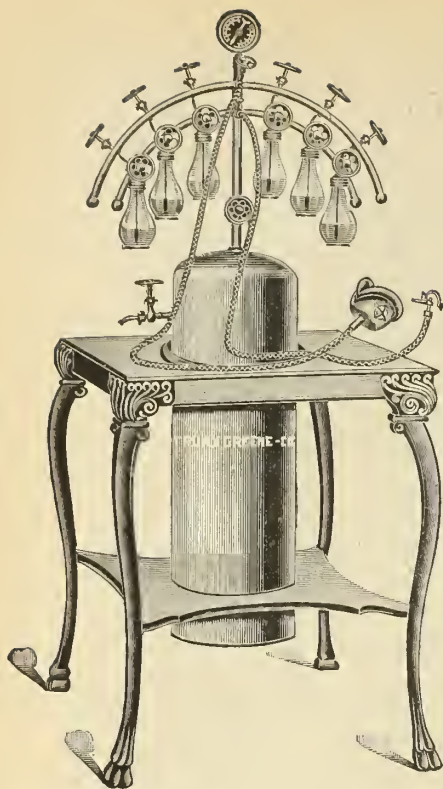
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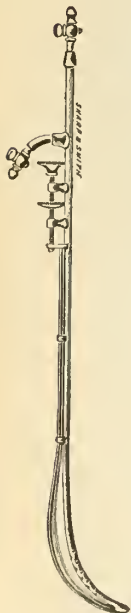
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# ILLINOIS Medical Journal

The Official Organ  
of the  
State Medical Society



Monthly Under Direction  
of the  
Judicial Council.

Printed by

THE ILLINOIS STATE  147 JOURNAL COMPANY.

Entered in the Springfield Postoffice as Second-Class Matter.

Volume LII.  
New Series, Vol. IV. }  
Number 5.

Springfield, Ill., October, 1902.

{ Subscription, \$3 a Year.  
Single Copies, 25 Cents.

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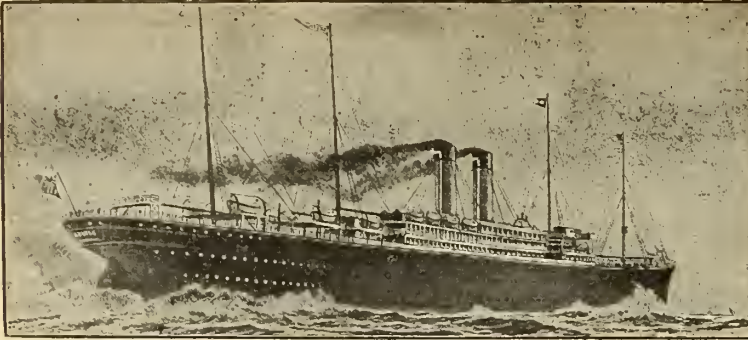
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VOL. LII.  
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NO. 5.

Springfield, Ill., October, 1902.

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## REPORT OF NINETY CASES OF TYPHOID FEVER IN INFANTS AND CHILDREN.\*

BY ISAAC A. ABT, M. D., CHICAGO.

This report consists of a study of ninety cases of typhoid fever, conducted for the largest part in the Children's Ward of the Michael Reese Hospital. A few of the cases occurred in my private practice. The report covers a period of three years.

The children were largely of Russian parentage. A history of conditions previous to the onset and prior to admission to the hospital was not always accurately obtained. A source of error in these histories is frequently due to the difficulty in obtaining accurate data from parents.

During the three years in which the cases were collected there was no particular epidemic of the disease. During the winter and early spring, it was rare to treat a single case, whereas during the month of June a few cases began to come in, the number increased in July, and by far the largest number of cases were admitted during the months of August and September. From this time on, a few cases occurred until December 1.

*Age of Occurrence.*—Even in recent years it has been maintained that typhoid fever in children under two years of age was of extremely uncommon occurrence. De Grassi-court<sup>1</sup> found only three cases in children as young as two years, in 276 cases of typhoid. Vogel<sup>2</sup> collected 1,017 cases, only four of which occurred in the first year of life. Morse<sup>3</sup>, who has rendered great service by his classical report on this subject, found no case in a child as young as two years. Holt<sup>4</sup> has never seen a case in a child of two years of age. It must be remembered, however, that the clinical as well as the post-mortem diagnosis of typhoid fever in

very young children, has been in the past impossible in many cases. The Widal reaction has been of great service in enabling us to diagnose cases which previously passed for another disease, or were not diagnosed.

There can hardly be doubt any longer that fetal typhoid can occur. Morse<sup>3</sup> summarizes concerning this point, as follows: "The typhoid bacillus probably enters directly into the circulation causing a form of general septicemia; therefore, the intestinal lesions in fetal typhoid are absent. Fetus usually dies in utero, or shortly after birth. Fetus may be born alive; if so, it is feeble, lives for a short time. Death usually occurs in a few days without definite symptoms. The fetus is not infected in every case."

In my series, the youngest child was 8 months old. One was 17 months of age; 1 was 21 months; 5 were 2 years old; 5 were 4 years old; 7 were 5 years old; 5 were 6 years old; 6 were 7 years old; 5 were 8 years old; 7 were 9 years old; 9 were 10 years old; 7 were 11 years old; the remainder were between 12 and 14 years of age.

The eight months' old patient was a male child. The mother and a brother two years old were in the hospital at the same time, ill with typhoid. The disease in the eight months' old patient was ushered in by fever and vomiting. Roseola over abdomen and buttocks was distinctly present a few days after admission. The spleen was enlarged; the temperature was constantly high; the abdomen was tympanitic. The diagnosis was made by the course of the disease and positively confirmed by the Widal reaction. One case, a child, twenty-one months old, died. The autopsy showed the usual abdominal and intestinal findings of typhoid in young children. The solitary and agminated follicles were swollen without ulceration; mesenteric glands and spleen were enlarged. This was a case in which multiple gangrene occurred, and has previously been the subject of a special report<sup>5</sup>.

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

*Prodroma and Mode of Onset.*—The majority of the children were admitted after they had been ill a number of days, and for this reason accurate data as to prodromata and onset were not obtainable. In the older children prodromal symptoms were usually present. In smaller children the onset was frequently abrupt. A sudden rise of temperature was recorded in all the cases of young children; vomiting at the very beginning occurred nineteen times in our series. Convulsions are said to occur rarely; in one of our cases the onset was thus marked. Diarrhea was present ten times. Constipation was more frequent and occurred sixteen times.

Headache was more frequently complained of than any other single symptom except fever. At the beginning of the disease forty-two patients complained of this symptom. Chill, or chilliness was not infrequently recorded at the onset of the disease.

Epistaxis, which is said to be less frequent in children than in adults, occurred four times during the early days of the disease.

Delirium was present once. Pains in the abdomen and muscular pain were each present thirteen times. The well known symptoms such as anorexia, prostration, malaise, nausea, insomnia, pharyngitis were frequently present during the prodromal and initial period of the disease.

*Pulse.*—The observation of the pulse confirmed the dictum of Gerhard<sup>6</sup>. The younger children showed a rapid pulse, while older children followed the type of adults and had a slow pulse. In fifteen of our cases, irregularity and intermittence of the pulse was noted for an uninterrupted period. In forty-two cases it was above 120 during the febrile period. Excluding cases of collapse and one of perforation, the pulse never exceeded 150 per minute in any case. In one case a relative bradycardia was present during the febrile period; the pulse varied from 50 to 70 per minute. In eleven cases it varied between 88 and 100 per minute.

*Fever.*—It was a common observation that the temperature of the patient immediately after admission was a maximal one for that day, the fever frequently falling one or two degrees after the patient had been placed in

bed. This reduction was partly to be explained by the bath which the patient received upon admission. The high initial temperature is due to the excitement and fatigue incident to the journey to the hospital as well as the unsuited environment and mismanagement of diet and hygiene previous to admission.

The study of the temperature records in our cases teaches us nothing new. The course of the fever was in almost every case of the remittent type. The disease was ushered in, in not a few cases by a high temperature, 104 to 105 degrees being not uncommon. In none of the cases did the temperature fall by crisis; it fell gradually in every case. The typical course of the fever was changed by complications such as pneumonia, abscesses, etc. We were convinced that the temperature was affected by emotional excitement. Nearly all of the children showed a rise on visiting days, when the parents and friends were permitted in the ward. This, however, caused no permanent effect on the fever curve.

*Relapse.*—In nine cases, or 10 per cent., relapse occurred. Most of the relapses were mild and short attacks, although a few were severe and exceeded in intensity and duration the primary attack.

I have under my care in the hospital now a little patient who is suffering a second relapse, i. e., a third attack of the disease. The last relapse was preceded by twenty days of normal temperature and apparently complete recovery. During the relapse period the spleen again becomes enlarged and the roseola usually reappear as in the primary attack. None of the children among my cases who suffered relapse died.

*Nervous System.*—As has already been noted, the onset of the disease is very frequently characterized by the occurrence of nervous symptoms. Headache is one of the commonest symptoms. At this period convulsions are rare. Headache was complained of by fifty patients—in three, throughout the febrile period. In a large number of the milder cases, apathy was manifest. These patients slept a great deal, but responded to questions. In older children, delirium

was commonly observed. This condition was very marked in thirteen cases.

In one little fellow nine years old, who had been ill all told, about five weeks with a severe attack, and of whom the parents spoke as having been bright previous to this illness, showed unmistakable signs of dementia after the appearance of the fever. He laughed or giggled in an idiotic way, most of the time and insisted on lying in bed uncovered and exposed. He took a fiendish delight in soiling the bed clothes and linen almost as fast as the nurses could change them, and he masturbated unabashed in full sight of the nurses, internes and other patients.

Among the younger children, those under the fourth year manifested their nervous state by great restlessness, and almost incessant crying. In two of the severe cases, marked and persistent stupor was observed. Tremor of the extremities and of the tongue was commonly observed in the severe types of the disease. In two cases, tremor of the tongue was persistently present. It was a common observation, during the height of the fever, or during the period of deferescence and early convalescence, that the knee-jerk as well as the abdominal and cremasteric reflexes were increased. Ankle clonus was frequently obtained during the same period. Meningeal symptoms were observed in two cases. The histories of these two cases are as follows:

P. L., aged three years, was taken suddenly ill with high fever. The temperature rose to 104; and remained more or less constant in character. He complained of excruciating headache; vomited frequently. He very soon passed into a comatose condition; there was extreme rigidity of the neck; continued high temperature, somewhat irregular pulse, the pupils were regular, there was slight deviation of the eyes. The reflexes were increased, and ankle clonus was present. The Kernig sign was marked. The Widal test was made on the second day of the disease and submitted to the municipal laboratory, who reported a positive reaction on the third day. The meningeal symptoms persisted unchanged. Frank Billings saw the case in consultation with me on this day.

He suggested that another Widal reaction be made by the municipal laboratory. The report of this reaction was again positive. Dr. Billings saw the case again with me on the fifth day, and at this time the meningeal symptoms had entirely disappeared. The case presented all the characteristics of a straight typhoid. The disease ran an uneventful course from this time on, and the patient made an excellent recovery.

July 21, 1901. M. F., aged 9 years. Born in Chicago of Russian parentage. Onset ten days before entering hospital. Onset marked by severe headache and violent vomiting. Headache gradually increased in severity and at the end of three days child was delirious, and very irritable and restless. About this time the parents noticed rigidity of the limbs and neck. Child had some diarrhea.

Past illnesses: No history.

Family history: Parents well, other members of the family well. No hereditary nervous, or mental conditions known to exist.

Environments: Lives under very unhygienic conditions; poor water, poor milk supply, and irregular food. Many cases of typhoid among neighbors.

General appearance: Fairly well nourished boy, with appearance of extreme illness.

Head: Long, peculiarly shaped. Pupils widely dilated, react to light. Mouth dry and brown. Tongue covered with brown fur and furrowed. Teeth bad.

Throat: Dry and red. Considerable rigidity of the neck.

Thorax: Fair general development. Respirations shallow and somewhat irregular.

Lungs: Negative, except harsh respiratory murmur and a few scattered, moist rales.

Heart: Outline normal; apex fourth intercostal space; one cm. inside mammary line. Tone weak; soft systolic murmur over apex. Second pulmonary not loud.

Pulse: Good quality, about 100. Not dicrotic.

Abdomen: Spleen enlarged, sharp, hard edge, easily palpable under ribs.

Liver slightly enlarged.

Extremities negative. Genitalia negative.



Nervous system: Marked acute delirium, maniacal in character. Muscles of extremities and neck rigid, and reflexes exaggerated greatly. Ankle clonus very marked.

Skin: Abundant crop of rose spots; taches cerebrales easily elicited.

Glands slightly enlarged.

Urine: Trace of albumin and a few hyaline casts. Diazo reaction positive.

Widal reaction positive. Blood count: Whites, 3,000; reds, 2,800,000.

The eyegrounds were examined and found to be negative.

Lumbar puncture: Clear fluid, nothing in smears or cultures. No result from injection into animals.

When the patient had been in the hospital one week the meningeal symptoms disappeared suddenly. The case ran an uneventful typhoid course from this time on. His temperature became normal on the eighteenth day after admission and remained so from that time on. He was discharged after a stay of thirty-seven days in the hospital, fully recovered.

*Tongue.*—The tongue is described as dorsum white and tip and edges red in thirty-six cases; is covered with a dry, brownish fur in six cases and as intensely red in one case. The white or grayish-white tongue with red border and tip, is regarded as the most characteristic for typhoid, though it is by no means always present. The appearance of the tongue is not always the same, and may change from day to day.

*Stomatitis.*—Stomatitis was observed in four cases, and gingivitis alone in one case. Infection of the mouth occurred in spite of the most scrupulous care. No symptoms were observed other than local discomfort in the mouth, though the food was not so readily taken and an increased flow of saliva was observed.

*Herpes-Labialis.*—Herpes-labialis occurred in four cases. This condition has been thought to be very infrequent, though that it does occur, is attested to by numerous reports in the recent literature.

Epistaxis, all told, occurred sixteen times. In two cases, excessive bleeding occurred; in three, it occurred during the prodromal

period. In one case it occurred daily during the first week of the disease; in another, it preceded by a day the appearance of the relapse. In one case it was severe and persistent and caused great exhaustion.

*Intestinal Symptoms.*—As has already been stated, constipation was frequent during the first days of the disease. Constipation occurred during the course of the disease in thirty-six cases, so that daily enemata were necessary to unload the bowels. In seven cases, diarrhea occurred during the first week and frequently constipation existed throughout the course of the disease. In twenty-eight cases diarrhea occurred; in two it was slight; in three the stools were offensive and in two it was severe. In ten cases the bowels moved once or twice daily without assistance. The stools were not characteristic for typhoid. In the younger children the stools showed undigested milk; they were fluid and contained a considerable quantity of mucus. Fecal impaction occurred in two cases, and in each during the period of convalescence, before the patient had been fed solid food. In both these cases slight temperature occurred at the time, associated with tympany and a feeling of fullness and distress in the rectum. These cases were relieved by the manual extraction of the hardened and tenacious fecal masses.

*Hemorrhage.*—Intestinal hemorrhage occurred five times. In two it was slight. In one, a moderately severe hemorrhage occurred only once. In one case two distinct attacks of hemorrhage occurred. Hemorrhage is not so frequent in children as in adults. It occurs most frequently at the end of the second week. The ages of the patients in whom hemorrhage occurred, ranged as follows:

Six years old, 8th day of relapse.  
Ten years old, 11th day of disease.  
Twelve years old, 7th day of disease.  
Ten years old, 6th day of disease.  
Eleven years old, 8th day of disease.  
Two were girls and three were boys.

Tympany was present in fifty-five cases; though it was rarely severe.

Perforation occurred in one case. The history of the case is of great interest and it is reported in full:

M. S., aged 10 years, of Russian parentage, entered the hospital after an illness of three days, complaining of headache, malaise, anorexia and diarrhea. The eyes were bright and face flushed; tongue heavily coated and some hyperemia in throat. The spleen was palpable two fingers below the costal arch. On entrance, the temperature was 102.8; pulse 128 and respirations 40. The temperature ranged between 98 and 104.2 with the morning remission and evening rise, of one to two degrees, accompanied by a pulse varying between 84 and 130. Temperature by gradual decline was normal on the 16th day after admission, and remained so for three days. In twenty-seven hours it again rose to 103.8 and continued with the usual morning remission accompanied by a pulse ranging from 100 to 160. On the thirty-third day after the relapse and on the fifty-fourth day after entering the hospital, at about midnight, the patient complained of severe abdominal pain and vomited some curdled milk. The temperature during the previous day was about 102.4; at 9 P. M. it was about 102.6 and at 12 was 101 with a pulse of 136 and respirations 32. At 3 A. M. the temperature was 101 with pulse of 180 and respirations 64. The patient was restless, the skin was cold and clammy and presented the peculiar facies. The abdomen was tympanitic and very tender. The radial pulse was almost imperceptible. At 5 A. M. the pulse was 160 and the respirations 48; at 6 A. M. temperature was 104.8, pulse 176, respirations 44.

The patient was taken to the operating room at 8:30 A. M. for operation. E. Wyllys Andrews, the attending surgeon to the hospital, who was on duty, was summoned.

A perforation in the small intestine, pencil-point in size, was found after opening the abdomen. The perforation occurred in the middle of an excavated area which was about the size of a five-cent piece. There was abundant evidence of beginning fibrinous plastic peritonitis in the neighboring coils of intestine. The ulcer was inverted and sewed, a Lambert suture being used. The peritoneal cavity was flushed with saline solution. The child showed considerable shock

during the operation and toward the end was almost pulseless. The abdominal wound was closed with silkworm gut and sealed with collodion. After returning the child to her bed, active methods of stimulation were employed. A saline infusion was given subcutaneously and hypodermics of strychnine and digitalin were also administered.

The pulse at the time the patient was returned to her bed was 152; the highest pulse after the operation was 160 and respirations not above 48. The temperature fell rapidly from 103 at noon to 97 at midnight; it did not again rise over 100.2 until the eighteenth day after operation, when for several days she had an evening temperature of about 102, due to the development of abscess on the extremities. The patient finally left the hospital on the ninety-fifth day after admission in excellent condition, having gained in weight and was discharged as fully recovered.

The Widal reactions in this case were positive; the urinary findings were negative except for numbers of leucocytes and a slight albuminous reaction with Tanalt's test. No casts were found.

*Liver.*—The liver was carefully examined in all our cases. In twenty-five cases the liver was somewhat enlarged. It was markedly enlarged in one case. One of the cases that came to autopsy showed a condition of catarrhal cholangitis.

More attention has recently been paid to the study of the liver and gall bladder in typhoid fever than hitherto. The catarrhal form of cholangitis, such as occurs in our case, has received but little mention. Curschmann<sup>7</sup>, writing on typhoid fever, says that the microscopic examination of the liver in typhoid fever shows more or less change in every case, depending upon the severity of the infection. The liver cells first show cloudy swelling, and later on granular degeneration and fatty change. Eventually they may break down entirely. The gall bladder may be the seat of ulcerative, or a diphtheric process on its mucous surface. Secondarily the larger bile ducts may be involved with secondary changes in the liver, leading to abscess. Accordingly to the researches of Chiari<sup>8</sup> and Birsch-Hirschfeld<sup>9</sup>,

the typhoid bacilli are almost constantly present in the gall bladder in cases of typhoid fever. Talma<sup>10</sup> has shown in an experimental way that by injecting typhoid bacilli into the gall bladder, that a general, though mild angio-cholitis developed, preceded by a cholecystitis. A careful review of the literature shows few cases of this variety of catarrhal cholangitis, as a complication of typhoid fever. Cases of suppurative cholangitis secondary to cholecystitis, have been more frequently reported.

An adenoma was also found in this same case. This must be regarded, however, as an accidental finding. It bore no relation to the typhoid infection.

In another case a girl of ten years came to autopsy. In this case the liver showed a condition of acute hematogenous hepatitis. The central vein, the capillaries and the interlobular vessels were congested. In the center of the lobule, the liver cells showed fatty degeneration. Small cell infiltration occurred in the interlobular connective tissue and also between liver cells. Small areas of focal necrosis were observed. There was an increase of interlobular connective tissue, with formation of new bile ducts.

*Pancreas.*—In the above mentioned case, the histological examination of the pancreas showed an acute interstitial pancreatitis. There was congestion of the vessels and small cell infiltration in the interlobular and intraacinous connective tissue.

*Spleen.*—The spleen was palpable in eighty-four cases. Not infrequently the splenic enlargement was observed during the first week of the illness. Tenderness, upon palpation of the spleen was seldom observed. In several cases where the spleen had been excessively enlarged, the involution of the organ was gradual and not infrequently was not complete until two weeks after the cessation of the fever. We learned, however, that the continued persistence of enlarged spleen was to be looked upon as probable evidence that a relapse would occur.

*Lungs.*—Bronchitis is very often observed during the first week of the disease; it occurs in most of the severe cases and may

occur in those of mild type. It was noted forty times in our cases. Broncho-pneumonia occurred five times and lobar pneumonia twice.

*Heart.*—Endo-cardial systolic murmurs occurred in thirteen cases. These were for the most part undoubtedly accidental murmurs, as they disappeared during convalescence. In five cases a diagnosis of mitral regurgitation was made, with compensated heart. These probably antedated the occurrence of the typhoid. In one case the heart was markedly irregular, with somewhat rapid pulse. This condition continued for several weeks. An acute myocarditis was suspected in this case. The patient recovered.

*Skin.*—The roseola was seen during the first few days; it was not uncommon to find it developed in the third or fourth day after what appeared to be the actual onset of the disease. It was noticed to gradually disappear as convalescence occurred. Our records show that roseola occurred fifty-five times on the abdomen. In one case it lasted undiminished for twenty-five days. In sixteen cases the rash appeared over the abdomen and thorax; on abdomen and buttocks in two cases; in iliac region in one case; on axilla and abdomen in one case; on flexor surface of arms in one case; over chest, abdomen and buttocks in one case. The rash with perhaps one exception appeared in crops during the course of the disease so that a number of spots could be seen every few days, the old ones disappearing in the meantime. In one case the roseola became the seat of purpuric spots. Sudamina late in the febrile period and during convalescence were observed in four cases.

Furunculosis occurred in twelve cases. In two cases general furunculosis occurred. In eight cases, abscesses of large size were found under the integument in various parts of the body. Onychia was observed in one case.

*Erythema.*—A diffuse erythema is not uncommon in any febrile affection. An erythema occurring early in the disease may confuse the diagnosis particularly if a pharyngitis be present. Erythema occurred eight times. In one case it was diffuse over the entire body; in one it was localized; in



one it was transitory and in one it was confined to the faec.

Urticaria occurred in one of our cases, early in the second week.

Bedsore and multiple gangrene occurred each in one case.

Desquamation was observed in ten cases. It occurs during the convalescent stage, and consists of exfoliation of fine scales. The exfoliation is not as extensive as in scarlatina, but resembles more the desquamation of measles.

*Special Sense Organs.*—Involvement of the middle ear in typhoid fever of children is comparatively frequent. Otitis media occurred five times; once it was bilateral; four times it occurred only in one ear.

Severe conjunctivitis was observed twice. The pupils were dilated in a very large number of cases; this was observed particularly during the height of the disease.

*Urine.*—The test for the Diazo reaction was made in nearly every one of our cases; it was noted to be absent nine times. Its value in this disease depended upon the fact that it occurs in a large proportion of the cases at some time during the disease. The reaction is most pronounced after, or during the second week of the disease. The reaction occurs in acute miliary tuberculosis, chronic tuberculosis, measles, scarlatina, malarial fever, pneumonia and other diseases. The reaction depends for its occurrence upon the fact that fermentation and decomposition are going on in the intestinal tract and the products thus manufactured are being absorbed, and in due time eliminated by the kidneys.

The urinalysis showed the specific gravity in more than two-thirds of the cases to be 1.018, or less. The presence of albumin was noted in eight cases. Hyalin and granular casts in thirteen cases.

The bacteriological examination of the urine in fifteen of our cases was carried on by H. E. Davies. His report is summarized as follows:

1. R. C. No typhoid germs found, but *B. coli* on 31st, 40th and 44th days.
2. M. F. Typhoid germs found on 34th, 42d and 46th days, with albumin and ea.

3. R. L. Typhoid germs found on 20th, 28th, 37th, 44th, 50th, with albumin.

4. F. I. No typhoid germs found, but *s. p. aureus* on 21st, 30th, 37th and 53d days, with albumin.

5. W. B. Variety of typhoid germs found on 24th, 33d, 41st days; no albumin.

6. F. K. *S. p. aureus* on 23d, 31st, 40th and 48th days; no albumin.

7. R. H. No typhoid, but *B. coli*, or a variety of typhoid on 40th day; much albumin.

8. I. L. Typhoid germs on 40th, 44th and 50th days, with albumin and *s. p. aureus*.

9. P. G. No typhoid germs, but *M. ureae* on 14th, 21st and 28th days; albumin also on these days.

10. B. F. Typhoid germs on 22d, 30th, 39th and 47th days, with *S. p. albus* and albumin.

11. H. M. No typhoid except possibly a variety on 27th day; no albumin.

12. S. S. No typhoid, but *M. ureae* on 14th, 22d, 30th days; no albumin.

13. I. W. Typhoid germs on 20th, 28th, 35th days, with albumin and pus.

14. A. M. No typhoid germs, but *B. coli* on 16th, 23d, 31st, 38th days; no albumin.

15. M. F. No typhoid germs, but *B. coli* on 12th, 20th, 28th, 35th, 44th days; no albumin.

*Summary*—Out of ninety specimens of urine, representing fifteen cases of typhoid fever, seventeen specimens representing five cases showed the presence of typical typhoid bacilli.

2. In eighteen specimens, varieties of the *Bacillus coli* and of the typhoid germs were found.

3. In the greater number of cases the typhoid organisms were first found from the end of the third to the middle of the fourth week of the disease. They may, however, make their appearance as early as the end of the second, or as late as the fortieth, or forty-fifth day.

4. The typhoid bacillus when accompanied by other species especially the *staphylococcus pyogenes aureus*, may occur in such small numbers as might easily escape notice.

5. As pointed out by Horton-Smith<sup>11</sup> and Petrusky<sup>12</sup>, the typhoid bacillus may be found in the urine in such large numbers as to render the urine turbid.

6. The largest numbers of typhoid bacilli in the urine are more likely to be found just after the height of the fever, or the beginning of the defervescence, from which time they usually decrease in number as long as the examination continues.

7. In the cases examined by me, where the bacilli of typhoid was found, albumin was always present, frequently in large quantity.

8. In the cases which contained the typical typhoid bacillus, pus was almost invariably demonstrable, even although in many cases no pus microbes were present. This would seem to lend additional support to the theory that the typhoid bacillus may itself, under certain conditions, be a pus producer.

9. The results here presented, as well as those of other investigators, demand that a systematic bacteriological examination and centrifugalization of all urines from typhoid cases should be made.

10. When the typhoid bacillus is detected by this means some measures of prophylaxis should be taken against infection. From the first appearance of the typhoid bacillus until it disappears, rigid disinfection of the urine should be practiced. The ideal prophylaxis would be attained by preventing the development of the typhoid germs in the urine. One means of accomplishing this result would be the administration to the patient of small doses of urotropin, as first recommended in the cases of Richardson.

*The Blood.*—The Widal reaction was made in every case, most frequently in our laboratory. The dilution was made in the proportion of 1 to 20. Later the technique was changed so that the dilution was 1 to 40. The result was considered positive, if, at the end of thirty minutes, agglutination was complete and motion arrested. The Widal was reported positive in all but two cases. It is difficult to state on what day of the disease the Widal was found to be present. Many of the patients were ill a number of days before admission, though in several

cases it is safe to say that the Widal was positive on the second and third days of the disease. The Widal was found as late as the fortieth day.

The blood in typhoid patients presents characteristic features. The hemoglobin gradually diminishes during the course of the disease; the number of red corpuscles also decrease in a gradual manner during the febrile period. At first the red cells are unchanged in form; later, they may be seen to vary in size. If the anemia becomes severe, poikilocytosis may occur. More rarely, nucleated reds, normoblasts and megaloblasts may be seen.

The leucocytes at the onset of the disease are neither increased nor diminished. At the end of the first week the number begins to decrease, so that at the end of the third week leukopenia exists. If complications such as pneumonia, perforation and peritonitis set in, leucocytosis occurs.

The findings in one case were as follows: L. M., admitted September 11. Discharged November 9, 1901.

Date.	Leucocytes.	Reds.	Hemoglobin.
Sept. 12.	9,000	4,810,000	73 per cent.
29.	6,300	4,680,000	70 " "
Oct. 14.	6,750	4,520,000	63 " "
28.	6,600	4,160,000	68 " "

In seven of our cases, other members of the family were ill at the same time with typhoid. In ten cases, the report was made that typhoid was prevalent in the neighborhood where the patient lived.

Out of the ninety cases treated, two died. These have already been referred to. One girl eleven years old, died as the result of a severe attack of the disease, with changes in the liver and pancreas and extensive ulceration of the bowel. The other child, aged twenty-one months, suffered from multiple gangrene and catarrhal cholangitis.

*Treatment.*—The treatment which we employed was the same that is everywhere in vogue. It may be divided as follows:

1. Hygienic.
2. Dietetic.
3. Hydrotherapeutic.
4. Expectant and symptomatic.

A large proportion of the cases ran the entire course of the disease without receiving any drugs. Patients were kept in bed and as near as possible, absolutely quiet. They were encouraged to change their position in bed frequently. This enforced rest in bed could not be strictly adhered to in young children; it was necessary to pick them up on account of restlessness, or to change their napkins and for their baths. The mouths were kept scrupulously clean by washing with boric acid solution. The usual precautions concerning the prevention of bed-sores by rubbing the back with alcohol, was practiced.

Only a few visitors were allowed in the ward at a time and if a number of patients were ill, visiting was abolished. During the febrile period the patients were kept on a liquid diet, consisting almost exclusively of milk, except in those rare cases where milk could not be borne. After the temperature had fallen to normal, strained gruels, broths and fruit juices were permitted. The patients were all encouraged to drink large quantities of water. No solid food was allowed until the tenth day of normal temperature.

The treatment of the temperature was hydrotherapeutic. A temperature above 102 was treated by tepid sponging; if the temperature rose still higher and was not reduced by the sponging, the patient was placed in a cold pack. In those cases where the fever was not controlled by either of the foregoing, the patient was given a full bath. He was placed in a comfortable, warm bath of about 90 degrees F.; this was gradually reduced to 80 degrees F. We found it rarely necessary to reduce the temperature of the bath much below this point. At times, however, where the fever did not yield, the bath temperature was reduced to 70 degrees or 75 degrees F. No antipyretic drugs were employed to reduce the temperature in any case. In those cases showing nervousness or restlessness, an ice-bag applied to the head, sometimes gave relief. At times a small dose of Dover's powder, or sodium bromide was given for restlessness and sleeplessness.

Constipation was treated by enemata and

cases of severe diarrhea were given small doses of deodorized tincture of opium. In the prolonged cases which showed the exhausting effects of the disease, where the pulse was rapid and weak, whisky, or brandy was employed, and moderate doses of strychnia were given. A child ten years of age was given 1.100 of a grain of strychnia three or four times a day. A child three years of age was given 1.200 of a grain three or four times a day. Intestinal antiseptics were rarely employed.

It is unnecessary to go into further detail concerning the various complications and conditions which arose and required special attention. Such complications and conditions were treated as they arose, on a rational plan. At the close of the febrile period, patients were frequently given a tonic in a routine way, the favorite being the elixir of iron, quinine and strychnia.

#### REFERENCES

1. De Grassicourt. *Traite Clin de Mal. d'Enf.* ii. 511.
2. Vogel. *Lehrb. d. Kinderheilkunde*, 10 Aufl. 152.
3. Morse, J. L. *The Boston Medical and Surgical Journal*, 1896.
4. Holt. *Diseases of Infants and Childhood*.
5. Author. "Case of Multiple Gangrene Complicating Typhoid Fever." *Journal of the Am. Medical Association*, August 17, 1901.
6. Gerhard. *Handbuch der Kinderkrankheiten*, 1877.
7. Curschmann. *Nothnagel's System of Medicine*.
8. Chiari. *Prager Med. Wochenschrift*, 1893.
9. Birsch-Hirschfeld. *Lehrbuch der Path. Anat.*
10. Talma. Quoted from Gould's *Year Book*, 1902.
11. Horton-Smith. *Transactions of Medical and Surgical Society*, London, 1897.
12. Petruschky. *Central Blat of Bakteriologie*, 1898, xxii.

#### Discussion.

George B. Dock, of Ann Arbor, Michigan (by invitation): It is very kind of you to ask me to open this discussion, and I appreciate the honor. I do not, however, feel that I can



add anything to what Dr. Abt has so ably presented to you, as he has thoroughly covered the ground. I have been very much interested in typhoid fever in children, but have not had much clinical experience with this disease in these young patients. I was very glad indeed, therefore, to have had an opportunity of hearing Dr. Abt's paper. It has confirmed many of my opinions.

**A. C. Cotton**, of Chicago: So able a presentation should not go without at least a word of commendation, for the very reason that it is ground that has not been extensively worked. Our knowledge or any exact information concerning typhoid fever in very young children is of very recent growth. I think it was not more than ten years ago that the late Dr. Charles Warrington Earle read a paper before the American Pediatric Society, in which he recorded thirteen cases of typhoid fever in young children. The discussion of that paper became very stormy, and brought out some assertions of a very positive character against the possibility or probability of typhoid fever in infants under two years of age. So able a man as Norbury, who, for many years, was the pathologist of the Foundlings' Home in New York, and who had performed at least three thousand post-mortems on children, declared that the records of that institution failed to show one single instance of typhoid fever in a child which had been demonstrated and confirmed on the post-mortem table. He said that although the ward records showed a large number of diagnoses of typhoid fever ante-mortem, none of the cases had been corroborated at the autopsy. Such an authority as that and the positiveness and correctness of his findings made it rather difficult to answer his assertions. Many practitioners even at that time believed that they had met typhoid fever in young children. Of course, the diagnosis had to be made from the clinical symptoms alone, and until the adoption of the Widal test, the subject was still *sub judice*. Since then this discussion has been taken up by some very eminent workers, like Dock, of Ann Arbor, Musser, of Philadelphia, and many others. The very able record and report of the large number of cases to which Dr. Abt has referred will certainly add strength to the contention that typhoid fever is met within infants beyond any doubt whatever.

This paper was very well presented, and the cases are very graphically described by the Doctor, for which the whole profession is under obligation to him. But it shows that the clinical history of typhoid in infancy is decidedly atypical from the adult standard. Some fifteen years ago we had to break away from the old German clinical type of typhoid, in order to get rid of such terms as typhomalaria, pneumo-typhoid, and other misleading terms, because we were trying to make our cases fit the old German standard type. We must have iliac gurgling, and we must have rose spots, and we must have meteorism, and, above all things, we certainly must have diarrhea. The older members of the profession will remember this very well. In 1883 men like Loomis, Flint,

Janeway and others took part in a very earnest discussion as to whether the disease as prevailing at that time was typhoid or not, and one of the obstacles was that they did not have the required diarrhea. How short a time ago that was, when we had to have diarrhea. Now, with our children, if we find by the Widal test, and the infant is undoubtedly susceptible to the reaction of the Widal test, that typhoid is quite prevalent among children, and there is no anatomic nor clinical reason why children should not have typhoid, except perhaps that they are not so much exposed to the infection with typhoid, because they derive their food from what is usually considered an aseptic source, it goes without saying that the case is one of typhoid, even if the symptoms are not classic. I, myself, have seen a large number of cases of typhoid in children, and I am firmly convinced that my diagnosis was correct, but we must not expect to find the typical symptoms of typhoid in the infant as we find them in the adult.

**J. Sloey**, of Lebanon: It so happens that I have under my care at the present time a little girl with typhoid fever. She has fever, gurgling in the bowels, temperature, which rises in the evening and is lower in the morning, and she is severely constipated. I tried all kinds of purgatives, but did not succeed in getting her bowels to move. The case at first was rather mild, and I did not suspect typhoid until I was called in about a week ago, when I found all of the typical symptoms of typhoid. I have had several cases of typhoid fever in children in the last few years, that I unhesitatingly pronounced as such. One was a little girl about six years of age whose morning temperature was much higher than the evening temperature, usually a variation of five or six degrees. She was also very constipated. My entire treatment in that case was saline injection. The fever continued for about ten days, and then dropped to the normal. Another case, a little boy, was nearly in the same condition. He was very restless, throwing himself about a great deal, and even becoming unconscious at times. I used the same treatment as in the previous case. I would give him a high rectal injection of salt solution, after which he would go to sleep very promptly. I find that that treatment is far better than the one I used years ago, namely, calomel. It seems to me that it is the most rational mode of treatment. I think it cannot be disputed that children have typhoid fever, although the course of the disease may be somewhat atypical.

**Frank Billings**, of Chicago: I think a further word should be said in reference to the good work done by Dr. Abt. It is just such work as this that is of decided value to us in our medical work, and it ought to be encouraged.

With regard to the question brought up by Dr. Cotton as to the clinical phenomena of disease manifesting themselves in different ways from time to time, and the various methods of diagnosis, I wish to say that while the primitive methods were sufficient in the old times, they were really not sufficient from

our standpoint, and consequently frequent disputes arose as to the correctness of the diagnosis, between the clinician and the pathologist. Today all that is different. There are so many better methods of making a good diagnosis in all of our affections and with these the existence of typhoid fever in infants is no longer a matter of dispute.

The Widal test is undoubtedly of value, but unfortunately it is not always present in the early stages of the disease. More recent investigations have shown that one can find the typhoid bacilli either in the stools or by making a culture directly from the blood much earlier than we get the agglutination phenomenon with the Widal test. The test is very easily performed, and simply requires the apparatus necessary for withdrawing the blood, and getting the serum, and the culture material which is necessary is always easily obtainable. A diagnosis based upon these methods, either laboratory or clinical, or both, will always help us to decide whether the patient has typhoid or not.

### CONTROL OF VACCINES, ANTITOXINES AND BIOLOGICAL PRODUCTS.\*

BY ADOLPH GEHRMANN, CHICAGO.

Variability of this class of products. Difficulties in production. Reasons why uniform standards are not maintained. Control from the standpoint of production. Control from the standpoint of use. Suggestions as to supervision and interpretation of results.

LABORATORY, DEPARTMENT OF HEALTH.  
May 19, 1902.

The rapid advance of animal therapy has placed at our command a considerable number of biologic products and to those already in use others will be added as the result of future experimentation. This is a part of progress in medical science.

Only such agents as have passed the experimental stage can be considered as subjects for control. As soon, however, as the principal facts regarding them are settled and a definite utility value is established it should be possible to have a mutually agreed standard for each, so that the properties and description of the product can be clearly understood by every physician.

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

Since the introduction of diphtheria antitoxin in 1894 a continuous examination of antitoxin and vaccine products has been made in the Laboratory of the Chicago Health Department. Products from many sources and obtained under widely different circumstances have been tested. This experience has convinced me that it is possible to produce products of this class of a high grade of efficiency and purity and to hold such a standard over long periods. But it requires close scrutiny and continuous vigilance. On the other hand, a wide variation from what might be called standard has been noted by us both in products purchased from drug stores and also even in special samples received for test.

As obvious facts regarding impure products I will only refer to the recent literature without comment.

Tetanus in Antitoxin, St. Louis Medical Courier.

Tetanus in vaccine, McFarland Wilson, Journal A. M. A., May 10, 1902.

Bacterial Content of Vaccine, American Medicine, April 19, 1902.

Editorial, Journal A. M. A., May 17, 1902.

Possible variations in diphtheria antitoxin are first as regards extraneous bacteria and decomposition. On this point all evidence at hand indicates that decomposed sera are very rare. I have only one recorded instance, although upon several occasions, where the antitoxin was credited with producing abscesses and infection, an examination of the remaining serum in the bottles was made, and these tests showed no living bacteria.

Second as to the number of units contained. What a unit of antitoxin strength indicates should be more generally understood. On some packages of antitoxin the term immunizing unit is used. If this is based on Behring's original description it should represent only one-tenth the strength of the antitoxic unit. Uniformity in this particular would be most desirable. As regards the number of units it has happened in several tests that specimens bought in the open market and also received for special investigation have had from 25 to 50 per cent less unitage than indicated on the label.



In one particular vial, marked 2000 unites, the test showed only five hundred units. Antitoxin from the same producers examined at different times have given both excellent and poor results. From this experience I should not condemn the product of a particular producer, but would only do so upon continuous observation. On the other hand it would be as unjustified to consider a product satisfactory without similar continuous observations.

The following note taken from the monthly Bulletin of the Chicago Department of Health is from a calculation by F. W. Reilly, and indicates a possible condition as regards vaccine. The failures in this particular instance were due to the distribution of about 20,000 tubes of untested vaccine during the rush of vaccination at the time of opening schools. These were replaced and after test were reapplied to cases of failure. The recurrence of such failure has since then been avoided by arranging for the supply a longer time before the schools opened. In this way tests can be repeated if some lots fall below the standards.

**Inert Vaccine Lymph.** During the year 1897, the Department distributed 126,800 tubes of glycerinated vaccine lymph to its public vaccinators, and obtained 82,804 successful vaccinations and revaccinations—an average of a little more than one and one-half (1.53) tubes for each successful result. From January to May inclusive and in October and November 63,600 successful results were obtained from 72,940 tubes distributed—an average of 1.14 tubes for each success, or 87.7 per cent.

During the first eleven months of the present year, (1898) 75,610 tubes have been used with only 25,864 successful results—an average of nearly three (2.92) tubes to each success, or 34.2 per cent. During the last four months the figures have been even more unsatisfactory—45,090 tubes and only 12,124 successes, an average of 3.71 tubes each, or less than 27 per cent.

Without further detail at this time it is evident from these gross figures that the producers of glycerinated vaccine have yet much to learn before they can be relied on

to furnish a uniformly potent as well as pure lymph.—Monthly Bulletin, Chicago Health Department, November, 1898.

The bacteriological examination of vaccine is very important. Experiments made during 1895, by myself and Dr. Garrett, formerly medical officer in the Department, showed that in glycerinated lymph the pus bacteria were destroyed in 50 to 60 days without any loss of potency and that a further period of 40 to 50 days could safely be assigned for the period of usefulness; after which time, slow but sure deterioration took place. The use of vaccine that has not remained in glycerin long enough is dangerous. The supuration caused by the pus bacteria masks the real evidence of vaccination and causes the painful infections that are dreaded by the public.

There are several reasons for variability in the products. Foremost must be placed the entire absence of any defined standard. The production of each kind of antitoxin, vaccine or extract is a matter of difficulty and requires more than skillful manipulation. Organisms have to be cultivated and selected through a continuous series to maintain their characteristics and a high grade of virulence. It is one worker to each culture and if one day is missed a complete failure may result. It is true therefore, that much individuality is represented in this line of work and the particular product is often due to the special ability of some scientific observer. It is further limited in amount; each man can only produce so much and if he goes beyond this there is danger of irregular results. The fact that the products are of temporary utility and have very definite limitations is the cause of failure when these limitations are not clearly understood. Biologic preparations are not permanent, but must be produced continuously whether used or not. This might lead to a purely commercial reason for variation in some cases, but I should not consider this a matter of importance.

The facts, both clinical and experimental, seem to make it clear that some regulation and assistance in procuring and maintaining pure and active preparations is much needed.



The methods of continuous control by tests and experiments as used in the Chicago Department of Health regarding antitoxin and vaccine makes it possible always to guarantee the products used. The excellent results as shown from the clinical study attests to this fact. As regards the producers it is my opinion that some manner of control would be acceptable to them because present criticism would then be removed and a wider and more certain confidence would result. By the physician it must be at once approved if it can give us always a high grade product. Of my personal knowledge I have instances where the last means of a family was used to purchase a vial of antitoxin, and the result of its use not being satisfactory, the physician himself has purchased additional vials for use in the case. It would also assist in making the patient more confident. He would accept these remedies as readily as those now listed in the pharmacopea.

The recorded experience of the antitoxin administrators of the Department make it clear that prompt and decided results are to be expected from the use of a full strength antitoxin. These results are summarized in the Bulletin of January, 1901.

In October, 1895, antitoxin was first used. In the five years to December 31, 1900, 5,727 cases of verified diphtheria were treated by the administrators with results as follows:

Total cases.....	5727
Total deaths .....	389
Per cent mortality.....	6.79%
Per cent mortality	
Treated on 1st day.....	.42%
2d day.....	1.54%
3d day.....	3.54%
4th day.....	11.38%
Total cases intubated.....	585
Per cent recovered.....	71.29%
Per cent died.....	28.71%
Total cases immunized.....	4831
Total number subsequently con-	
tracting diphtheria .....	25

These 25 and all intubated cases are included in the general statistics.

Recognizing fully the variation of severity in diphtheria infection, the cases of slow or

partial action of antitoxin that have come under my observation must be due to less units given than required, and this is corroborated by experiments that show the occasional small per cent of the indicated number of units that is actually present in the vial. A very recent test made by Dr. Evans showed that out of 15 vials examined 5 vials contained the number of units indicated.

By what scheme is control to be obtained? The following possibilities suggest themselves.

Government manufacture.

Government inspection.

State inspection (under Food and Drug Acts.)

Pharmacoepal recognition.

Special commissions.

This is not a matter for casual consideration. The control must not be loosely conducted. The absolute necessity requires a product upon which undoubted reliance can be placed. From the use of diphtheria antitoxin alone Dr. Reilly has calculated that the saving of life in the city of Chicago for the five years 1896-1900 inclusive, has amounted to \$22,780,000, if based on the legislative value of human life. Not one case can afford to be lost.

Government manufacture is not necessary and I should be against it, because it would limit private enterprise.

As an example of Government inspection, the German method may be cited. Diphtheria antitoxin is tested by the official testing station and the vials are sealed by it before being placed on the market. Such a station could be established by the Marine Hospital Service or inspectors could supervise production and testing in the laboratories of producers. Vaccine is produced in Germany at the official impf-stationen, and a careful record of each lot and the results obtained is kept. The reports of every physician using a particular lot is therefore at hand as a means of controlling the work done in the station. Control by the state would naturally come under the present arrangements as outlined in Food and Drug Acts. Certainly special facilities would be required. These departments are now

practically limited to chemic investigation and there can be no reason why they should not be equipped for every kind of scientific investigation. Drug inspection has been a matter of difficulty in most states, but it has been principally because no definite requirements are stated in the laws. I should not consider such control as entirely satisfactory but it may be advisable because it should be easy to obtain.

The committee on revision of the pharmacopea have the subject of listing biological products under consideration, and it is probable that some favorable action will result. The chief difficulty that presented itself was as regards the advisability of introducing tests that require animal experiments, or bacteriologic methods. If it is not possible to establish these at this time a beginning should be made by listing the more important products supplemented by

#### Definition

General characters and source

Physical properties

Rules for preservation

They should not be sold by the druggist like patent medicines. He should understand the reasons for deterioration and the limitations of the products, and be able to keep his supply up to the requirements.

The advisability of a commission of the American Medical Association or some other body to report is an open question. The British Medical Association is proceeding in this way. Under any circumstance it can only be temporary and cannot conduct continuous control. Information can be obtained, but control is too laborious and expensive for a commission, and they could not enforce changes as required by the findings of investigation. I should therefore advocate the placing of these preparations in the pharmacopea and controlling them by a system of either state or national inspection.

### MILIARY TUBERCULOSIS.\*

BY FRANK X. WALLS, M. D., CHICAGO.

Since Ponfex demonstrated a tubercular lesion of the thoracic duct in a case of

miliary tuberculosis, and Weigert found a caseous lymph node communicating with a branch of the pulmonary vein, the explanation of the miliary dissemination of tuberculosis has been elucidated. For the occurrence of acute miliary tuberculosis, it is necessary to presuppose a primary tubercular focus and from this site the entrance of abundant bacilli into the blood stream. This penetration may occur directly into an artery or vein or indirectly into the blood stream through the thoracic duct. The entrance can usually be discovered post-mortem after careful search, though it may readily be overlooked. Cornet says that from an ulcer of 1/10 of a millimeter in circumference an area that is not recognizable macroscopically over 100,000 tubercle bacilli can simultaneously march through a vessel wall. The question might occur, "Why is not miliary tuberculosis more frequent in phthisical individuals?" The reason probably is that the action of the tubercular poisons on the surrounding tissues is towards encapsulation and limitation of the tubercle bacilli, and if the focus be near a vessel wall, the poisons are diffused beyond the histological tubercle in advance of the bacilli themselves, and set up a plastic inflammation with thrombosis and obliteration of the vessels. In children, on account of the wider and more porous lymph vessels, the poison is more quickly and widely diffused into the surrounding tissues. Because of its wide diffusion and dilution with the tissue fluids, the toxins are less potent, and may reach the blood vessel wall without occasioning any considerable local irritation, so that the rapidly multiplying bacteria may reach and penetrate a blood vessel which has not undergone conservative thrombosis. The younger the individual, the less the tendency to tubercular limitation, and the more readily may a blood invasion occur; consequently, we find miliary tuberculosis more frequent in the young. Certain factors favor the occurrence of miliary tuberculosis. All irritants, mechanical, inflammatory or other kind, which excite the pre-existing tubercular focus, increase the liability to the development of miliary tuberculosis. Espe-

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

cially to be mentioned in children are measles, whooping-cough and influenza, which frequently awaken a dormant tubercular focus and occasion a rapid extension into an adjacent blood vessel. Trauma may rupture an encapsulated focus and cause its quick dissemination; enough may be regarded as a form of trauma which, acting on the bronchial glands may tear the gland capsule and liberate the tubercle bacilli. After operations on tubercular bones, or joints, or tubercular tissue, not uncommonly, tubercle bacilli enter the open blood vessels, grow into them and become disseminated.

The location of the primary tubercular focus explains the pathologic anatomy of miliary tuberculosis. The lungs, spleen, liver, kidney, bone-marrow, and meninges are the organs most frequently studded with tuberculosis, but no tissue of the body is exempt from tubercular localization. Miliary tuberculosis may be general or local, depending upon whether the tubercle bacilli entered the general circulation or penetrated some part thereof.

The symptoms that are present in miliary tuberculosis, are due to the systemic poisoning with the tubercle protein and partly to local tubercular formation. The symptoms are both general and local. Among the general symptoms we may consider fever. The temperature rises often without prodromata to  $102^{\circ}$  to  $103^{\circ}$  and, as a rule, is not so high as in typhoid. In the charts I exhibit, this characteristic of the temperature is well illustrated. The temperature range being from  $101^{\circ}$  to  $103^{\circ}$ , while in typhoid, with corresponding general symptoms, the temperature would average 1 or 2 degrees higher. The fever is of no definite type. In the subacute cases the irregularity of the temperature is of some diagnostic value. Sometimes it is continuous or irregularly remittent. In the very acute cases, a continuously high temperature much like typhoid or perhaps the inverse type may be observed. Exceptional cases have been reported in which the temperature never exceeded  $98.6^{\circ}$ , and this group of cases is analogous to the afebrile course that typhoid, pneumonia, or

sepsis may pursue in rare instances. The pulse, as a rule, is said to be very frequent, small, soft and occasionally dicrotic. In the cases here presented on the contrary, the pulse was not accelerated until the course of the disease was nearly run.

Date.	Temp.	Pulse.	Resp.
April 1—1 a. m.....	102.	82	15
3 p. m.....	101.6	80	—
8 p. m.....	101.2	—	28
April 2—2 a. m.....	103.2	81	31
5 a. m.....	101.6	74	30
9 a. m.....	102.6	—	—
5 p. m.....	101.4	—	—
8 p. m.....	102.	60	30
11 p. m.....	—	64	—
April 3—3 a. m.....	102.2	75	30
7 a. m.....	101.8	81	27
9 a. m.....	102.3	76	31
11 a. m.....	102.4	—	—
3 p. m.....	—	—	35
7 p. m.....	101.2	83	29
8 p. m.....	101.2	83	29
10 p. m.....	102.	—	—
April 4—5 a. m.....	101.8	—	—
6 a. m.....	101.8	85	30
8 a. m.....	102.	85	31
12 m. ....	102.4	—	29
6 p. m.....	102.2	—	—
10 p. m.....	102.6	79	26
April 5—3 a. m.....	102.3	—	—
6 a. m.....	102.8	89	25
9 a. m.....	102.6	84	32
2 p. m.....	102.8	92	37
7 p. m.....	102.7	89	35
April 6—3 a. m.....	—	85	27
5 a. m.....	103.	84	30
8 a. m.....	102.	89	29
4 p. m.....	102.6	86	35
7 p. m.....	101.6	85	31
April 7—2 a. m.....	102.6	79	29
6 a. m.....	102.6	92	27
11 a. m.....	102.8	88	28
2 p. m.....	103.	90	28
3 p. m.....	103.	—	—
5 p. m.....	102.5	—	—
9 p. m.....	102.8	88	28
April 8—8 a. m.....	102.4	—	—
11 a. m.....	101.6	96	34
3 p. m.....	103.2	94	—
10 p. m.....	102.7	90	30
April 9—1 a. m.....	102.1	88	30
5 a. m.....	102.2	98	28
6 a. m.....	102.4	—	—
8 a. m.....	101.1	94	33
3 p. m.....	102.6	91	38
6 p. m.....	102.6	—	—
8 p. m.....	102.	90	30
Apr. 10—1 a. m.....	103.	90	30
5 a. m.....	102.7	—	—
9 a. m.....	103.6	94	31
11 a. m.....	102.	—	—
5 p. m.....	103.2	—	34
April 11—2 a. m.....	102.8	—	36
8 a. m.....	102.6	94	33
3 p. m.....	102.	92	34
April 12—8 a. m.....	102.4	96	34
4 p. m.....	—	—	—
7 p. m.....	101.4	—	—



Date.	Temp.	Pulse.	Resp.
Apr. 12—10 p. m.....	101.2	—	—
12 p. m.....	100.8	—	—
Apr. 13—5 a. m.....	101.8	—	—
3 p. m.....	101.8	104	37
5 p. m.....	—	98	—
Apr. 15—8 a. m.....	101.	—	33
1 p. m.....	101.6	—	34
6 p. m.....	101.8	—	38
Apr. 16—1 a. m.....	102.4	98	—
6 a. m.....	102.	100	—
7 a. m.....	101.6	100	35
12 m.....	100.8	100	34
7 p. m.....	102.8	102	39
Apr. 17—1 a. m.....	102.5	90	30
6 a. m.....	102.5	86	29
1 p. m.....	102.8	—	—
4 p. m.....	—	—	40
6 p. m.....	103.2	90	46
12 p. m.....	102.7	104	33
Apr. 18—8 a. m.....	102.9	115	33
1 p. m.....	102.	103	32
7 p. m.....	102.6	110	37
11 p. m.....	103.2	110	35
Apr. 19—6 a. m.....	103.	104	30
6 p. m.....	101.6	120	44
11 p. m.....	102.4	112	36
Apr. 20—4 a. m.....	100.	108	38
7 a. m.....	101.8	112	46
2 p. m.....	102.6	112	35
6 p. m.....	102.8	116	44
12 p. m.....	102.	120	46
Apr. 21—4 a. m.....	101.9	124	42*
8 a. m.....	102.5	120	40
10 p. m.....	102.	128	38
Apr. 22—3 a. m.....	102.9	114	42
7 a. m.....	—	112	48
11 a. m.....	102.6	112	42
3 p. m.....	102.8	112	34
10 p. m.....	103.2	120	36
Apr. 23—6 a. m.....	103.2	114	38
7 a. m.....	102.6	114	32
12 m.....	103.	114	36
6 p. m.....	102.2	112	40
12 p. m.....	102.9	112	36
Apr. 24—6 a. m.....	102.2	112	40
10 a. m.....	103.	—	41
1 p. m.....	103.	116	48
2 p. m.....	103.	—	43
7 p. m.....	103.	116	43
12 p. m.....	101.2	124	50
Apr. 25—6 a. m.....	101.4	112	48
8 a. m.....	102.8	116	45
1 p. m.....	103.4	118	43
7 p. m.....	103.6	118	50
11 p. m.....	101.4	154	62
Apr. 26—1 a. m.....	100.4	112	50

Expired 2:10 a. m., April 26, 1900.

\*Extremely restless.

The heart exhibits a tendency to become weak, and may precipitate a pulmonary edema. In rare cases a hemorrhagic diathesis is present with profuse bleeding from the nose, gums, intestines or other organs. Respiratory symptoms are usually early present and strikingly prominent. There is some cough, which is frequent

and paroxysmal. The respirations become fast, even 90 in children, combined often with very marked dyspnoea which is remarkable in that the physical findings do not explain it. (Vagus irritation.) Later, the Cheyne-Stokes respiratory phenomena may be present. The sputum consists of a sparse, foamy, colorless mucus containing no tubercle bacilli unless there exist an ancient tubercular focus in the lung, but it may contain blood from some ruptured capillary or perhaps it may be rusty from an accompanying pneumonia. Symptoms on the part of the nervous system are especially prominent whenever there is any involvement of the the meninges or brain. In many cases the sensorium is remarkably clear in contrast to the dull lethargic state in typhoid. Headache, delirium, shrieking, sighing, teeth-grinding, hyperesthesia, convulsions and particularly with spinal and basal meningeal involvement, frequent vomiting, changeableness of pulse, strabismus, alteration in the size of the pupils, painful stiffness of the neck and Kernig's knee-symptom are met with.

The digestive and urinary symptoms are such as occur in profound systemic intoxication. The mouth and tongue are dry with black coating, there may be scorbutic gums, frequent nausea and vomiting (meningitis.) The stools are undigested, there may be diarrhoea, perhaps blood (ulceration.) Loss of strength is an early symptom and emaciation is, as a rule, steadily progressive and extreme. The urine is dark, contains much urates, may be albumin, or anuria may occur. In the event of nephritis the usual findings in the urine will be present. Involuntary bowel movements and urination may occur.

On a part of the skin a most valuable symptom is cyanosis, observed particularly in the lips, nose, and fingernails—cyanosis in the absence of extensive pulmonary or cardiac signs. Sweating may be profuse. Certain eruptions on the skin have been observed, roseola and erythema nodosum, and herpes, when a mixed pyogenic infection. Miliary tubercles in the skin are very rare. Towards the lethal termination there may be a considerable anasarca.

The physical findings on a part of the chest are those usually found in diffuse bronchial catarrh. Unless there be an extensive primary focus or some thoracic exudate, no change on percussion is elicited, though perhaps with the growth of tubercle a diminution of lung tension may occur and resonance become tympanitic. Auscultation reveals abundant rales, crepitating or subcrepitant or small mucous rales and what is of especial value is the disproportion between the physical signs and the existing cyanosis and hurried breathing. Gradually or suddenly the symptoms increase with exitus under the clinical guise of a lung edema. If the pleura is involved we may hear or feel a friction rub, and effusions are not uncommon. The heart frequently exhibits a systolic murmur, and the second pulmonary tone is more accentuated than is usual even in childhood. In the event of pericarditis a friction bruit might be palpated or auscultated, or the signs of effusion into the pericardial sac may be demonstrated. The spleen is usually large and may be palpable, but often it is so soft that it is hard to feel. In the choroid of the eye, Litten observed the miliary tubercles 39 times in 52 cases he examined with that point in view.

The duration of miliary tuberculosis may be anywhere from a few hours to many months. Perhaps an average time for the severe cases would be two to three weeks. In its course a certain symptom grouping may be followed so that there are described certain types of miliary tuberculosis, among the most characteristic being the typhoid, the pulmonary, and the meningeal types. These terms are sufficiently explanatory of the grouping and as may be surmised these types are variously blended.

The diagnosis of miliary tuberculosis is extremely difficult. The demonstration of tubercle bacilli in the blood is the single condition that permits a positive diagnosis of generalized miliary tuberculosis and this demonstration is by no means a simple task. With meningeal symptoms we might search in the cerebro-spinal fluid for tubercle bacilli or examine the choroid for miliary tubercles, or more rarely find them in the

pharynx or larynx. The sputum usually fails, but it should be searched as likewise should be the stools and urine for the specific bacteria. In the failure of the demonstration of the tubercle bacillus or its products as just indicated, a diagnosis might be assumed from the anamnesis, the grouping of the symptoms and after careful exclusion of other infections, particularly typhoid, malaria, cryptogenetic sepsis or septicopyemia, or where localizing symptoms are in the foreground, profuse bronchitis, pleurisy, pericarditis, and meningitis depending on other exciting factors must be differentiated. The prognosis is hopeless. The disease is almost necessarily fatal, though healing is possible.

The sole treatment is in prophylaxis; avoiding primary tubercular infection. In the event of a primary focus if it be operable it should be removed by surgical intervention, if inoperable, we should avoid those conditions that are known to assist in the dissemination of the tubercle particularly to be mentioned, exposure and the infectious diseases.

The case, from whom the specimen I exhibit was obtained, was a Polish boy, 1 year old. Very little of the family history was obtainable. The paternal history was unknown. His mother developed acute insanity a week before the child was taken to the hospital. Personal history. The infant was nursed by his mother until six months old, when mixed feeding was given. There was no history of any previous illness. The child lived in a crowded tenement and during the severest period of the past winter, he was carried out of doors all the day with insufficient bodily covering by his fatuous mother, who thought that in this manner to inure him to the hardships he must endure from their poverty. When the mother was committed to the hospital for the insane, the child was sent to the infant asylum. He was a child of large frame, pale skin and a considerable development of subcutaneous fat, and he weighed 21 pounds. His ribs were distinctly beaded and he had four teeth, the central incisors. Over both lungs, front and back, could be heard abundant dry,

medium sized rales. Otherwise the examination was negative. A week after admission it was observed that the child had a frequent dry, harassing cough, and had a poor appetite. A few days later he began to vomit after nearly every feeding and his cough continued. Examination of his chest revealed very many dry and moist rales diffused over front and back of chest. For another week the symptoms continued and it was apparent that he was losing flesh and strength each day. He had become very restless and would frequently cry out in a shrill voice and toss himself wildly about in bed. He had a short dry cough, at irregular and infrequent intervals, there was no sputum. The skin was dry and very pale with no exanthem or cyanosis. His urine became scant and contained some albumin with granular and epithelial casts. The respirations were somewhat accelerated and examination gave the signs of a diffuse bronchitis. He became progressively weaker and 20 days after his entrance into the hospital he died. The record of his pulse, temperature and respiration is appended. (p. 243-244.)

Twelve hours after death the examination showed the body moderately well nourished, and rigor mortis marked. Thorax. Right lung pale slatey color, crepitates feebly, base of a dark reddish color, but not consolidated. Left lung is in about the same condition as the right, except the lower part of the left lower lobe is much firmer, crepitates but faintly and in the substance of the lung there can be palpated a large number of very firm bodies about the size of small shot. The color of the base of the left lung is of a decidedly dusky-red hue. Under the pleura can be seen a great number of very fine sub-miliary granules that beset this portion of the lung. These granules are yellowish white in color with a ring of congested lung surrounding them. On section of the lung it is seen that the tubercles are confined to the lower half of the posterior lobe of the left lung. The bronchial mucosa throughout both lungs is slightly swollen and reddened. The mediastinal glands are enlarged, about a half a dozen to the size of almonds, very

hard on section, and of a glistening white color, with small areas of cheesy softness. Following the pulmonary artery into the lower half of the posterior lobe of the left lung, we meet with a caseous gland about the size of a Boston bean that has eroded, and lies exposed within the wall of the vessel, and the tubercles in the lung are confined to the area supplied by this branch.

In the intestines, four inches above the ileo-cecal valve is a small ulcer six m. m. in diameter with raised edges and smooth and level base. About the middle of the ileum there is a second smaller, and almost healed, ulcer. The solitary and agminated follicles are slightly swollen and pigmented. The mesenteric glands are enlarged some being almost an inch in diameter. The smaller glands are red and soft on section, and the larger ones are yellowish in color, and on section show irregular areas of caseous detritus lying in dense fibrous reticulum. The liver is slightly swollen and of normal color save a few pale yellow areas, but contains no tubercles. The spleen is of normal size and somewhat firm consistency. The kidneys are slightly enlarged. The capsule peels easily and on section the cortex is seen to be swollen with the markings in places blurred.

The report of this case and exhibition of this specimen, in addition to its general interest as a case of miliary tuberculosis, suggests a question of extreme interest; i. e. the relative frequency of primary intestinal tuberculosis, or better expressed, the frequency of generalized tubercular infection arising from the alimentary tract. The query expressed in the second way carries the wider interpretation. In cases of primary intestinal tuberculosis we understand a condition in which there is a demonstrable infection of the intestine with tubercle bacilli. In the second case there may be no recognizable lesion of the bowels. Leonard Pearson has shown from experiments in feeding animals with tubercular material that they may develop pulmonary tuberculosis without showing lesions of the intestine, though the infectious material reached the lungs from the intestines. This



specimen is indubitably one of primary tuberculosis of the intestine with generalized dissemination, and had not the accident of exposure and rupture of a caseous lymph node into a branch of the pulmonary artery occurred, the belief is warranted from the appearance of the intestinal ulcers that the intestinal tubercle bacilli were healing and in a short time would have left no trace of its former site. However, latent tubercles would have been present in that organ most predisposed to tuberculosis, and less resistant to its ravages, the lungs, and with sufficient impairment of the general resistance might have become diffused through the respiratory tract, and on post-mortem examination have appeared as though primarily pulmonary. Moreover, it is unnecessary that the tubercles coming from the intestine should travel such a slow and barrieaded road as in the present case, they may enter the lacteals and via the thoracic duct be poured into the blood stream to be arrested in the finer vessels of the lung.

#### WHAT SHALL WE TEACH THE PEOPLE IN REGARD TO TUBERCULOSIS.\*

BY GEO. W. WEBSTER, M. D., CHICAGO.

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The State Board of Health is charged with the duty of guarding the lives and health of the citizens of the state. It is its duty therefore to seek out and apply the best that is known in public hygiene and sanitary methods. But the best work cannot be done by the board alone, but must be accomplished by the co-operation of the people, and this can be secured only after they have become well informed upon sanitary subjects.

It therefore becomes our duty to answer the question, "What should we teach them in regard to tuberculosis?" What shall we teach the five millions of people of our state in regard to the most important disease which affects them; and their duty in regard to it? Much good has, we believe, been

accomplished by the Board in sending out Circulars of Information in regard to Smallpox, Scarlet Fever and Diphtheria, and we believe much more can be done by sending out a similar circular in regard to consumption. The following paper contains the essentials of a circular which I am preparing for distribution and I invite your criticism of both the method and the matter:

##### MODE OF DISTRIBUTION OF LEAFLETS.

1. To the newspapers as the educators of the public.
2. To local boards of health.
3. To teachers and principals of schools.
4. To all physicians in the state.
5. To families and friends of families where tuberculosis is known to exist.
6. To anyone making application.

Our efforts should be directed in behalf of the patients whom we desire to help and the public whom we desire to protect, and our instructions should be simple and practical rather than scientific, but above all things we should teach the truth.

Tuberculosis or consumption is an infectious, preventable, curable disease.

*Prevalence.*—1,500,000 human beings in the United States are suffering from it; 2,500,000 cows in the United States are affected by it.

The studies of Behring seem to refute the statements of Koch and support the contention that human and bovine tuberculosis are identical with the exception of slight morphological modifications due to environment.

*Cause.*—The disease is caused by the tubercle bacillus. The chief source of these germs is the sputum of consumptive patients. It is estimated that a case of moderate severity expectorates seven billions of these germs every 24 hours.

These germs are given off from the lungs with the sputum which is hawked or coughed up, cast upon the sidewalks or the streets, upon floors or carpets or public places, or upon the clothing. The sputum becomes dried up, mingles with the air and dust of the home or the street, from whence the germs may be breathed into the lungs, thus becoming the chief source of infection. They are very tenacious of life, resisting

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

ordinary destructive processes for months. They may be eaten by flies, live in their bodies, may be deposited by them upon food as meat and milk. They may be found on the floors, walls, etc., of the rooms of consumptives.

Thus the man who is able to do some work and goes about, spitting on the street, in the street cars, on the floors of the home, the workshop, or public places is a far greater menace to the lives of others than is the seriously ill patient, at home in bed.

#### MODES OF COMMUNICATION.

When we say that it is an infectious disease, this means that it may be communicated from one person to another, and probably from man to the lower animals, and from the latter to man. It is not necessary to have personal contact in order to become infected. The paths by which these germs enter the body are the respiratory and the digestive tracts chiefly; but they may enter through an abrasion of the skin of the hands or face or other part of the body. That is, the germs are either inhaled with the air, or swallowed with the food and drink, or gain entrance through some wound or sore upon the body.

*Heredity.*—From the remotest times, there has been a general belief in the influence of heredity in disease and especially consumption. Owing to a clearer knowledge of pathology, many of the diseases which were formerly thought to be the outcome of hereditary proclivity, are now known to be due to infection. Some diseases are directly transmissible, and in addition to this, there is an inheritance of structural peculiarities. In tuberculosis we have an example of the inheritance of both tissue modification and the disease itself. That is, the form of chest and type of tissue in which the disease develop most rapidly is certainly inherited. But what is inherited is not alone a tendency to tuberculosis, but an increased vulnerability to adverse conditions of all kinds. Such persons fall easy victims of tuberculosis, not because they have inherited the disease, but because they have inherited the kind of soil or tissue in which the disease develops most readily. Add to this that in

such families, there are usually some cases of consumption we have the patients who are especially prone to the disease placed in the most favorable circumstances for becoming infected. Most of those cases in which the disease itself is inherited die before the end of the first year. No case of tuberculosis in adult life is a case of inherited disease. It is always an infection. Few persons are born tuberculous; all are probably born tuberculizable. Some persons seem to possess unusual resisting power, are not easily infected, and this is known as immunity.

Susceptibility varies in different individuals and families as the result of hereditary differences, just as protection or immunity does. Both may be varied by diet, habits and mode of life. Thus the normal resisting power, immunity, may be diminished or even destroyed by overwork, worry, fatigue, great anxiety, bad habits, excesses, intemperance and extreme exposure. Thus rats which are naturally immune may be readily infected after being overworked and fatigued, or after being kept under the influence of alcohol for some time. On the other hand, children born of tuberculous parents, if removed from the likelihood of infection and properly reared, are likely to remain free from the disease. For example, over 15 per cent of the cows of Germany are tuberculous, and yet only one calf in every one hundred thousand is born tuberculous. Those calves born of tuberculous mothers and taken away from them and fed on pure milk do not contract the disease. If healthy calves are fed upon the milk of tuberculous cows, they become infected. We thus see that there are three principal factors in the problem.

1. The germ, the bacillus of tuberculosis.
2. A varying susceptibility to infection by it.
3. Two principal routes through which the germ enters the body; the respiratory and the digestive tracts.

To ignore any one of these factors is to fail in its solution; to recognize all three and the influence of each, as well as our limitations in regard to each, will be likely to

lead to the best results. Let us consider each in detail.

#### IS IT A CURABLE DISEASE.

Autopsies show that one-third of all persons have had some form of tuberculosis at some time in their lives, while only one-seventh die of the disease. In other words, one-third or 23 out of the 70 millions now living in the United States will have the disease and only one-seventh or 10 millions will die.

The other 13 millions will get well. We thus see that over half of all cases recover. This is amply confirmed by the clinical experience of all observant physicians.

#### RULES FOR THOSE WHO HAVE THE DISEASE.

*The Germ.*—It must be apparent that the destruction of all the tubercle bacilli would put an end to the disease, but desirable as this is, it is quite impossible. Our efforts must be directed towards reducing them to a minimum. The first rules should be in regard to the disposal of the human sputum as this is the chief source of the bacilli and hence the chief element in infection.

#### RULES.

**RULE 1.** Tuberculous patients should never, under any circumstances, expectorate upon the floors of the home, the workshop or public places, where the germ may subsequently be a menace to others. To do so is criminal negligence. Every tuberculous patient owes to his family, friends and society, to see to it that he disposes of his own sputum. Thirty-eight states recognize this fact by law.

The handkerchief should not be used as it may contaminate towels, napkins and wearing apparel of others. Old pieces of cloth, pieces of gauze or cheese cloth may be carried in small pieces and after use may be burned at once, or else placed in envelopes, preferably parafined, and subsequently burned. If cuspidors are used, they should always contain Standard Solution No. 1.

2. First of all, remember that consumption is a curable disease, and that one-half of those who have it recover from it.

3. There is no other disease in which so much depends upon the individual efforts of the patient. It is not so much a matter

of medicine as of correct living, proper food, climate, exercise, sleep and hygienic living.

4. While your first duty is to yourself, for "charity begins at home," your second is no less clear and imperative: You must not menace the health and lives of others.

Every person suffering from consumption suffers from a disease which may be communicated to other persons. This takes place through the spit, which contains bacilli. So long as the spit is moist it can do no harm, unless under such circumstances as are dealt with in rules 6 and 7.

The spit is gravely dangerous only when allowed to dry, becoming dust, and so infects the air we breathe.

The surest way to form infectious dust is to spit in a handkerchief and put it into the pocket or beneath the pillow, or to spit upon the floor.

The same results follow if spit is smeared over bed clothes, night dresses, etc., or, in case of men, over mustache or beard.

Practically then, a case of consumption may be made perfectly harmless by preventing the spit from becoming dust.

1. *Indoors.*—The greatest care is necessary. Dust in closed places is the dust which infects. Use a spittoon containing a little water (not sand or sawdust) or spit into a rag or piece of paper, to be burned at once or thrown into the water closet.

2. *Out of Doors.*—Dust is not so readily formed in our climate and it is disinfected by sunshine and fresh air. It is therefore better to spit on the ground than into a handkerchief, or into anything which is apt to be put in a pocket, except a special spit bottle, such as may be had for a small sum. Failing in this, spit into a gutter, never on the pavement, and never in a trolley, bus, cab or railway carriage. Never swallow the spit; it may infect the bowels.

3. If a handkerchief or other article is soiled with tuberculous spit, keep it wet until it can be boiled or washed.

4. Empty the contents of the spittoon down the water closet, and clean the spittoon with boiling water. A little carbolic acid will kill the flies; these carry off the infective matter.

5. In cleansing rooms occupied by con-



sumptives, capture the dust with damp dusters and tea leaves or damp saw dust used in sweeping. Do not chase it about or stir it up. Boil the dusters; burn the saw dust and tea leaves.

6. No spoon, cup or other article which has been applied to the mouth of a consumptive ought to be used by a healthy person until it has been carefully washed. The remains of food left by a consumptive ought not to be used by the healthy.

7. No consumptive ought to kiss or be kissed, except on the cheek or brow.

8. No consumptive mother should give such kisses.

9. Consumptive persons ought to have a bed by themselves.

10. Consumption is not communicable by the breath or perspiration. If these precautions are attended to there is no danger to the healthy in the ordinary intercourse of family or society.

During the currency of cases of tuberculous disease in which there is a discharge, the medical officers will give any assistance in the way of washing and disinfection which may seem expedient in the public interest.

Tuberculous patients should not be allowed to work at—

A. The care of cattle, especially cows.

B. The preparation of foods, as dairy maids, cooks, bakers, milk dealers, etc.

#### HYGIENE.

*Hygiene.*—Let us now consider the second element in our problem, susceptibility to infection. As we cannot destroy all the germs, our hope lies in everything which will enable the body to contend most successfully against invasion by disease; to prevent it if possible, and to fight it successfully after infection has taken place. There is truth in the old adage, here as elsewhere, that "an ounce of prevention is worth a pound of cure." Preventive medicine is dominated by the noblest motive that ever animated the human race.

#### GENERAL RULES FOR THOSE WHO ARE PRE-DISPOSED.

1. First of all is the law and the gospel of cleanliness. This means personal cleanliness in regard to the body, the teeth, the

hair and the nails. Cleanliness of the home, the streets, cleanliness everywhere.

2. Temperance in all things. Alcoholism is the most potent factor in the propagation of tuberculosis today. It not only predisposes to infection, but regular indulgence greatly increases the virulence of the infection and hastens a fatal termination.

3. Eat an abundance of properly cooked, wholesome, easily digestible nutritious foods. Be especially careful to avoid excesses in sweets or anything which will favor the occurrence of acid dyspepsia.

4. Live as much as possible out of doors and in the sunshine. Choose such work as will favor this, and avoid sedentary occupations and the professions. It is better to be a live farmer than a dead doctor.

5. Choose such exercises as will promote health and favor the expansion and development of the lungs and general vigor of constitution.

6. Breathe an abundance of pure air, both day and night. To do this it may be necessary to live in the country. It is better to be alive and well in the country than dead and buried in the city.

7. The house should be so chosen as to avoid a damp situation.

8. Select a climate, if possible, with at least a moderate elevation, preferably hilly, with a maximum of sunshine, a minimum of rainfall and warm enough to invite to out-door occupation, sports or exercises.

9. Sleep in a well ventilated room with an abundance of fresh air.

10. Avoid smoking rooms and smoking cars and poorly ventilated public assembly rooms.

11. Change climate in order to avoid the extremes of cold in the northern winter, or the heat of the southern summer.

12. Be especially careful to not live with consumptives, to not occupy premises formerly occupied by a consumptive unless such premises have been disinfected with great care and by sulphur fumigation.

13. Never eat suspected meat nor drink suspected milk.

14. The clothing should be of wool next to the skin in winter, and warm shoes should

be worn and every precaution taken to prevent taking cold.

15. Avoid mouth breathing. When there is any impediment to free nasal respiration in either the nose or throat, a competent physician should be consulted.

16. Give especial care to any pulmonary symptoms.

17. Above all things avoid everything which lowers the vitality and diminishes the resisting power, such as overwork, too little of long vacations, exhaustion from work or exercise, exposure.

18. Remember that you *have not inherited consumption*, but only a weak constitution, and that in no other disease does so much depend upon yourself and your own efforts.

19. Do not marry a consumptive or one who is predisposed to the disease.

20. Fifteen per cent of the cows of the United States are tuberculous and may be a two fold source of infection; through the meat and the milk. Therefore in all suspected cases, the meat should be well cooked and the milk thoroughly boiled. Merely heating it or bringing it to the boiling point is not enough. It should be boiled for twenty minutes.

21. There is no danger in living with tuberculous patients, so long as these rules are rigidly observed. In the Adirondack Cottage Sanitarium, devoted exclusively to the care of tuberculous patients, there has not been a case of tuberculosis among the physicians, nurses, or attendants in 15 years.

22. Gradual progressive loss in weight should make you suspicious and should lead to an expert examination of the lungs. This is especially true, if in addition to loss in weight there is increased frequency of the heart beat, with a slight fever in the afternoon that is increased by exercise.

*Disinfection:* All rooms occupied by consumptives should be kept scrupulously clean. Unnecessary draperies, carpets, etc., should be dispensed with. If sputum or other discharges accidentally fall on the floors or walls, the spot should be cleaned immediately with boiling water. The rooms and all the furnishings should be thoroughly

disinfected as often as once in four weeks at most.

1. The Breslau formaldehyde method or the use of sulphur are the methods recommended. The sheet process is unreliable.

2. All premises or rooms, sleeping car or steamer berths, occupied by a consumptive in a home, hotel, boat, car or hospital, should be as thoroughly disinfected before it is occupied by another as it would be in the case of small-pox. This should not be attempted by anyone except someone properly qualified.

3. All personal clothing, bed linen, handkerchiefs, belonging to a consumptive should be washed by themselves and very thoroughly boiled.

4. All dishes, spoons, knives and forks, etc., used by him should be thoroughly washed and boiled before being used by others.

*Notification.* All persons affected with consumption are urgently requested to notify either the local health authorities or the State Board of Health.

It should be distinctly understood at the outset, that there is no disposition or desire on the part of the Board to placard or quarantine the premises or in anyway to interfere with or curtail the rights of any one. The sole objects are to try to be of some service in curing those who are sick and preventing the disease in those who are well; to furnish information and help to those vitally interested.

Herman M. Biggs of the Department of Health of New York, at a recent meeting of the New York County Medical Society stated that as the result of 12 years of work and experience, there had been a reduction of over 35 per cent of the mortality from consumption in New York since 1886, and *attributes it largely to notification*. Some states have compulsory notification. Voluntary notification is far preferable.

#### CONCLUSIONS.

The man who expectorates in a vehicle or public resort, does not merely violate public decency, but commits an offense for which he should be punished. Health board warnings and placards in street cars avail nothing if not enforced. So long as women sweep

infected sputa with their dresses they will suffer from tubercular disease and communicate it; so long as the dust of dried sputa is disseminated and inhaled in public vehicles, every passenger is endangered. Men and women, especially women, are urged to form associations for the rigorous suppression of indiscriminate spitting, and Boards of Health will do better service to the community if they direct their best efforts towards the prevention of tuberculosis.

The segregation of those already afflicted in local sanatoria as advocated at the Berlin congress, will ultimately check the progress of this frightful scourge and add immensely to the sum total of human happiness.

#### Discussion.

**L. C. Taylor**, of Springfield: Dr. Webster has so thoroughly covered the ground as to what should be done for the regulation and prevention of the spread of tuberculosis, that it would simply be a repetition for me to attempt to discuss his paper, and I will, therefore, only refer to one obstruction which we have had to contend with and that is in regard to the manner in which people should be taught. In our cities that are more or less under political control, we have had considerable difficulty in getting the proper legal enactments which will teach people how to take care not to spread contagion. In our own town of Springfield, we thought some years ago, when the State Veterinary Commission ordered the killing of a large number of tubercular cattle, that it would be a good opportunity to give the people an object-lesson in regard to tuberculosis. We deputed some of the members of the State Board of Health to go to the members of the City Council and invite them to attend the slaughter of the cattle. We also extended a similar invitation to the press, and to the public at large. We thought that if they saw the cattle killed, they would appreciate the confirmation of the diagnosis of tubercular disease. Even after seeing some sixty or seventy cattle slaughtered, and seeing our diagnosis thoroughly confirmed, we still had the greatest difficulty in getting the City Council to pass a law requiring that all milk sold in the city should be brought from dairies that had a certificate of good health from the veterinary.

I think, from my own observation, that we have been a little behind other countries in promulgating some sanitary laws among the people. In the tramways of Vienna, and all of the public conveyances in Berlin and Paris, placards are put up by order of the Board of Health, announcing the danger of expectorating on the floor, and also that it is prohibited by law. They have gone a little further than this in Paris. For instance, in the mail stations they have caused to be placed large placards in which they describe, for the information of their employees, and the public as

well, the dangers attendant upon promiscuous expectoration, and the manner in which the disease is to be fought and eliminated. They have put on this notice the statement: "On account of the public health, it is ordered by the Sanitary Commission, that persons shall not expectorate on the floor, and that a violation of this law will subject the offender to arrest." That they have not gone quite so far in this country is evident from the placards we see put up right here in this hall. I have seen one which says that persons are prohibited from spitting on the floor. There is a placard in this room saying that persons are prohibited from spitting tobacco juice on the floor. It does not, however, prohibit anyone from throwing the tobacco quid on the floor or anywhere else. That placard is probably put up in the interest of the janitor, so as to lighten his labor, or perhaps it is simply a matter of cleanliness. They ought to go just a little farther. Our city councilmen and those who have charge of our public buildings can be taught to place placards in public places where people are assembled that it is not only forbidden, to spit tobacco juice on the floor, but that they are prohibited from spitting on the floor at all, no matter what the juice. It is the only way in which this law can be enforced, and this serious danger combatted. It is the physicians who should take this matter in hand, and we trust that Dr. Webster's pamphlet which the State Board of Health is sending to all the physicians in this State will be productive of the desired results.

**Robert H. Babcock**, of Chicago: Do I understand that Dr. Webster proposes to have embodied in his leaflet all the facts which he presented in this paper?

**Dr. Webster:** Yes.

**Dr. Babcock:** The paper is very exhaustive on this subject, and one can but commend all that has been said. It is questionable, however, whether in attempting to enlighten the public one should attempt to enlighten them too much at first. Would it not be better, perhaps, to enlighten the public on fewer things to begin with? The Doctor spoke of the inadvisability of the intermarriage of tubercular people or people having a tubercular tendency or inheritance. That is a matter of great moment, but I question whether such an item should be introduced into a leaflet which is to be distributed broadcast among the people. Let us begin by enlightening the people on certain points which we consider absolutely fundamental, and, of course, we all must admit that the first thing to be taken up is the spitting habit. We must spend all our energies toward instructing the people concerning the dangers of expectorating promiscuously, whether they have tuberculosis or not. Unfortunately, we all know that even medical men are careless about this thing, and if medical men are careless about public spitting, surely the people will be, and before we can succeed in having laws enacted which will control this matter, we must work up some public sentiment.

The second matter of fundamental importance is with reference to tubercular cattle and milk. The necessity of eliminating, so far as



possible, tuberculous cows from our dairies, and prohibiting the distribution of tuberculous milk is a paramount one. If that can be done, much will be gained. If that cannot be done, however, then the proper treatment of milk which is possibly from tubercular cows should be considered.

Third, the item concerning the notification of the Health Board of consumptive patients. That is very important, but I agree with the Doctor that it is hardly advisable at present to insist upon compulsory notification. But if we enlighten people concerning the benefit which is to arise from notification of the whereabouts of tuberculous patients, the thing can be accomplished just as efficiently as if we had compulsory notification. We cannot insist upon these things too emphatically, and it lies with every physician to instruct his patients, whether they are tuberculous or not, concerning these points. I hold from my own experience in coming in contact, in a consulting way, with many physicians, that most of them are altogether too careless and lax on these points, if, indeed, some of them are not absolutely ignorant of all hygienic principles, especially so far as pertains to the prevention of the spread of a contagious disease.

**Sanger Brown**, of Chicago: I have been wondering if, perhaps, we had not been drawn away somewhat from the hygiene of tuberculosis by Koch's discovery. I am rather afraid we have. Dr. Webster's emphasis of the importance of cleanliness as a matter of extreme moment is a timely one. Cleanliness can be readily carried out, no matter whether a person is rich or poor, and no one needs to spit in the cars or on the floors of public buildings. Public attention is very generally drawn to this tuberculosis just now, and any utterances of ours on this point are likely to be heeded. Therefore, we, as physicians and advisers of the public, should be sure that we give the best advice. I believe, however, that there is one thing which is of more importance than spitting and cleanliness, and which demonstrations during the last fifty years have shown to be of importance in preventing a spread of tuberculosis. I refer to ventilation, the ventilation of the home. Most elaborate experiments have been made in past years in armies and navies and especially those of Great Britain, where large bodies of soldiers have been kept in barracks, with limited ventilation, for years, and in all climates. When these soldiers had the same food, used alcohol in a similar way, and had the same habits, and were taken from narrow, close quarters, where ventilation was imperfect, and placed in barracks where the ventilation was good, the death-rate for tuberculosis has fallen as much as 75 and 80 per cent. This shows what ventilation will do.

The same is true on shipboard, and it seems to me that it is unreasonable that we should be led away from the main thing by a series of scientific investigations,—well made, to be sure, for I do not wish to detract from their importance in the least. Dr. Webster has alluded to ventilation in his paper, but I feel he has not emphasized it enough. Not many

months ago I heard an excellent paper read by Dr. Babcock, on the treatment of tuberculosis. He considered the out-door treatment of the disease, and said that it gave him the best results. That, in my opinion, is certainly the best treatment, and if we overlook it we will have to reckon with the public in the future. Ventilation means fresh air, and, therefore, we ought to go into the factories and offices where there is no ventilation and instruct the people along those lines. I think that would be very much more important than simple cleanliness, and should be insisted upon. Of course, we must expect to meet with some obstacles in this work. It is a matter of great expense and it will be difficult to get people who have offices to rent and who own factories to allow sufficient space for ventilation. We must stand firm and insist on that point, however, and disseminate education along these lines.

**R. C. Matheny**, of Galesburg: I would simply like to ask a question. There comes a time in all cases of tuberculosis where any real active treatment is devoid of any result, and I imagine that the outdoor treatment, which has been advocated so strongly, by Dr. Babcock, is also ill-advised at certain times. I would like to have Dr. Webster tell us, if he can, how long he would institute the outdoor treatment, and whether he can give us any idea as to the chance the tubercular patient has, so far as recovery is concerned, in advanced cases.

**Dr. Walker**, of .....: I believe it is a historical fact that tuberculosis was entirely unknown in the days of Abraham, when everybody lived outdoors. I think tuberculosis was also unknown among the American Indians until they began to live in houses or huts. I am convinced that ventilation is an all-important factor in the prevention of this disease, which is unquestionably a house disease. There is another important preventative, if you please, and that is physical culture. Of course, the newspapers make a great deal of sport of our Senator Mason on account of his bill in behalf of physical culture, but I believe it was the best ever introduced in the United States Senate. There is no question in my mind but what we have an over-dose of physical culture just now in our monthly magazines, but the outdoor treatment of tuberculosis, combined with physical culture, deep breathing, is the one method by which we can hope to cure it or prevent it. I have seen patients taking a course in some physical culture establishment do wonders without ever taking a drop of medicine. I have seen a man with tuberculosis, who was unable to walk at all, ride miles within three weeks on horseback and run along with his horse, and yet gain ten or twelve pounds; a man, fifty-five years old, at that. That was in 1899, and when I heard from him last he had gained thirty-five pounds. This is of course, a single instance, but I could go on and mention many others. The natural method of treatment is the best. We get too far away from nature in this climate. There are many air cells that we never use at all, and that is the place, in the apex of the lung, where tuberculosis usually takes

root and begins to develop. It is in these sluggish areas that the lung tissue is not active enough and affords a nidus for infection. Therefore, I think that in addition to the things mentioned in Dr. Webster's leaflet, we might effectually add how to teach people something about this deep breathing, and about living outdoors.

**T. J. Pitner**, of Jacksonville: Respecting the conditions that favor the development of tuberculosis, I have made some observations amongst people who are living in a colony in Jacksonville. They were exiles from their native country, and came to Jacksonville and Springfield and settled these two colonies, the only two in this country. They came from the Island of Madeira, where tuberculosis, as you are well aware, is unknown, and hence there was no hereditary predisposition to tuberculosis in any of these people. They had one habit which was very striking. It was their ambition to buy a little piece of ground and to build thereon a little house. They were people who wanted a home. They came from a land where such a thing as a stove was unknown. No heat was needed, but here it became necessary for them to heat this little house. It was a small house, and they heated it in the most economical way. A stove was usually used, and like all people coming from warm climates they could not get heat enough, and therefore every breath of fresh air was kept from entering into their habitations. No matter what the physician said, these poor people went on breathing and re-breathing the same air. The consequence was that they began to die in large numbers from tuberculosis. Our records in the city of Jacksonville show that since these people came in there we have had a much larger percentage of deaths from tuberculosis than before, and that most of it was not among the native population. I have practiced among these people for a long time, and know this to be a fact.

Long before Koch advanced his theories, we had computed that the element of contagion entered into the consideration of the etiology of this disease, and was a very important and prominent factor. The breathing-in of the impure air of the little home by these people was certainly not conducive to preventing the spread of the disease. The deaths from tuberculosis in those colonies are increasing year by year. The facts may, of course, be explained by one or both hypotheses, but both contributing the specific contagion—the transmission by contagion and then the condition of the impure atmosphere.

**A. W. Baer**, of Chicago: With regard to what we should teach people in the matter of prevention of tuberculosis, I, too, will refer to the American Indian. In his work on the Indian, George Catlin distinctly says that the Indians who live in the open air, breathe through their noses, and keep their mouths closed, very seldom or never have tuberculosis. As to the question of expectorating, it has always appeared to me that most of the expectorating that is done is simply a matter of habit. It is a fact that the more you expectorate, the more you want to, and you will

find that after a little time the uvula is lengthened out long enough to irritate the back part of the tongue sufficiently to create a desire or to compel one to expectorate more than usual. I have found that either by cauterizing the uvula with red heat or by snipping off the end of it, this expectorating habit is usually very promptly cured. One application of the cautery will usually reduce the habit.

**Dr. Webster** (closing the discussion): I am very sorry that in my effort to save time it was necessary for me to give merely an abstract of my paper, and not go into the details. In regard to the question asked by Dr. Babcock, as to the proposed method of distribution of these pamphlets, they were distributed as we distribute the other papers, first, to the newspapers; second, to the local boards of health; third, principals and teachers of public and other schools; fourth, to all the physicians in the State; fifth, to all tubercular patients, and to all those living in a neighborhood where tuberculosis is known to exist; sixth, to all those asking for them.

A short time ago we had an epidemic of scarlet fever in Evanston. Many people in that district became frightened, and asked me to send them instructions with regard to the care and prevention of scarlet fever. We at once sent out, on the same day, two thousand of our circulars considering scarlet fever, one to every householder living in that district. That is the same way in which we will send out these leaflets, where we know that they will do the most good. These leaflets are intended, not only for physician, but for everybody, the teachers and principals of schools, householders, and everyone else.

In regard to the question of ventilation, which was brought up by Dr. Brown, I have a whole page here in my paper devoted to the question of ventilation. I have even given the exact amount of cubic air space to be allowed for each person. I have tried to make a strong point of that. Indeed, I have tried to make two strong points. First, the danger from the germ, which we cannot control, and, second, how people should live, which we can control, by means of pure air, cleanliness, and good ventilation. You see, I tried to emphasize the importance of ventilation.

In regard to Dr. Matheny's question, how far a patient may go and still recover, that comes up under prognosis, and if I should talk on the question of prognosis, and consider all the elements that enter into it, I am afraid that it would consume all the time allotted to this subject.

In regard to the conditions which favor the development of tuberculosis, I think that they have been gone into sufficiently by the other speakers. The important point is, I believe, to educate the people in regard to these important principles of prevention, and then follow it up with specific rules on each point, what they should do, and what they should not do.

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Arrange now to attend the next annual meeting at Chicago next May.



## THE LIMITATIONS OF SURGERY IN GYNECOLOGY.\*

BY O. B. WILL, M. D., PEORIA.

Bearing on the subject of this paper, the writer entertains certain feelings which he finds some difficulty in expressing in terms of exact justice and circumspection.

He absolutely knows, for instance, as do others, that there is an alarmingly large proportion of gynecological cases subsequently coming under observation, in which operative interference has proven worse than useless in securing the comfort and health sought by the patient. Again, in an equally large per centage of women upon whom surgical treatment has been advised, he has seen complete recovery follow much less heroic and drastic measures. He could give in detail a tiresomely long list in each of these classes, from personal inspection, and made up from the work, not of amateurs alone, but from that of those in whom we are all accustomed to place the best of confidence. He would have it understood, therefore, that he is prepared to defend his position in this matter, and that he is not considering the subject merely from a sentimental standpoint, and without an adequate knowledge of the salient facts, at least.

But while observations of the kind mentioned are exceedingly impressive, and calculated to make one stop and think, it is difficult fully to place responsibility and suggest a practicable remedy. Mistaken diagnosis do you say? If so, more reprehensible is the radical practice. Certainly they argue a defect somewhere, not only individual competency, but in the consensus of professional public opinion which establishes no adequate standard of either moral or scientific justification. It is easy to escape personal culpability on the ground of legitimate variation in judgment, but certainly there should be some means of restricting the latitude of such variation, on the basis of generally acceptable indications, in order to avoid the gross blunders or worse which constantly tend to the dis-

repute of professional exactions. We seem to need not so much more facts, as more knowledge, strength and wisdom, in order to avoid faulty conceptions on the part of the average surgical mind.

The nebulous state of knowledge respecting the mutual relations of local and general physiology, and especially the misleading calculations on reflex influence, to say nothing of the marvelous therapeutic claims of undue enthusiasm, have proven deterrent to righteous but timid criticism. It seems fair to hope, however, that an effective reaction has begun, and it should be encouraged by every fair means at command. It is a cheering sign to see some of the formerly strenuous advocates of operative self-sufficiency creeping slowly to the defense of rational conservatism in both theory and practice. The more fear now is that in time the pendulum will swing too far the other way, and it would seem to be the duty of the evenly disposed to mark if possible a potentially vigorous line of limitations.

No one is now-a-days rash enough to arbitrarily place a limit to the advancement of science; but science and speculation are two entirely different things. There is such a confusion of the term with mere hypothesis and experiment, that one is justified in repressive considerations. The principles of common-sense recognize the relation of the whole to the part, as well as *vice versa*.

But while the needs of modern gynecology are marked by demands other than that of a mere riddance of disabled organs, likewise are they heavily indebted to thoughtful surgery, and the aim should be for a discriminative standard, to hold in check the forces of the erratic and impetuous.

By the term "limitations of surgery," etc., in this connection, therefore, is meant the extent of justifiable operative effort, of the several well-known types. In other words, the minimum of surgical endeavor compatible with relative local and general indications. The lines of demarcation, if you please, between the prudent and the imprudent utilization of the several distinct classes of operative procedure resorted to in the various gynecological disorders.

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.



While some of these limitations are self-evident, and consequently beyond discussion for present purposes, others are admittedly unmarked, and of such an evasive disposition as to prove embarrassing if not dangerous to all concerned. Under the head of what may be denominated "reparative" surgery, for instance,—as necessary in the lacerations—the limits are definite and fixed; self-indicative, the indications for repair being co-extensive with the degree of solution of continuity. The injured part, in other words, bears *prima facie* evidence of its special needs.

In "ablative" surgery, on the contrary, the circumstances are of quite different character. While it has been fully demonstrated that all the organs distinctive of sex in woman may be removed without necessarily sacrificing her conscious entity, no one would be willing to accept that limit as the approximately practical one in most cases. It is so broad, so all-inclusive as to be worthless as a guide to judicious effort. The extent of the pathology which calls for the ablation is sometimes uncertain. Difficulties in diagnosis, and ignorance or prejudice of other therapeutic methods and instincts have made the limit more indeterminate. It seems proper, therefore, to honestly attempt a delineation of those controlling features which appeal to common experience, and narrow the horizon of doubt and speculation. Such a differential effort will tend to fix personal responsibility, and stimulate greater care.

The possibilities of ablative surgery are involved especially with the ovaries, uterus and tubes. And it fortunately so happens that those organs are unusually available for approximate diagnosis. This must be accounted a distinct advantage in efforts at pre-limitation of operative needs. Accuracy in this respect tends to eliminate adverse criticism. It makes classification more secure, and serves to restrict ablative effort to its proper sphere. And finally, it offers a safe-guard against ignorant assumption, for the reasons to be pointed out.

The truth, established on the basis of growing experience, is that but a meagre field is now open to exsection. As laparo-

tomy for merely diagnostic purposes must be now mostly abandoned, so must exsection be eliminated excepting for distinct tumors or neoplastic developments, for absolute tissue disorganization, and for purulent or analogous accumulations. But even within this circle there are narrower lines of demarcation. The ultimate pathology is often more of a factor in results than eradication of the gross manifestation, and it is a good rule in surgery to make the limit of offensive action strictly coincide with that of the disease. When, therefore, it is called to mind that the ovary is essentially a cystic organ, that a part is identical in function with the whole, that enlargement does not necessarily mean disease and that degrees of preservation answer in measure physiological demands; when it is realized that patulous tubes are perforce in hopeful condition, that the uterus is an organ so constituted and situated as to be amenable to all necessary kinds of depletion and stimulation; that over and above all, the old theory and practice of evacuation along lines of least resistance have returned to plague the inventive genius that attempted to retire them, it must be readily seen that the sphere of ablative surgery is rapidly narrowing in the natural course of evolution, and that its limitations are on the verge of rational fixation. The whirligig of time works wonders, and shows that true progress is not always in the forward direction. An acceptance of its indications will restrain many an enthusiast from undue pettnosity, and avert many a galling criticism.

In this connection, and by way of a concrete illustration, I cannot refrain from a sharp word of remonstrance relative to the minor ablative operation of uterine curettage. The limits of prudence in this act are constantly overstepped, and the writer has seen hundreds of cases made worse by its use and abuse. Apparently no reasonable restriction in its application is recognized by the profession at large, and yet men of observation know that it is a most menacing procedure, and should be resorted to only with the utmost care, and under circumstances of specific need. It ought not be

done once where it is now done at least a score of times, and unless its just limitations are studied and responded to it must continue to be the cause of much disaster and disappointment.

But the storm-centre, so to speak, of operative effort in gynecology is now to be found in the field of what may be called "reconstructive" surgery. It is the one in which is shown the most misguided and ill-considered surgical enterprise. It is the direction in which operative exuberance finds its most promising outlet. It constitutes a variety of procedure in which the changes are constantly being rung with frightful rapidity, and apparently without regard to the anatomic and physiologic principles involved. This is illustrated, if not in the oft-repeated destruction of function, then in the mere exchange of one sensory evil for another, in nervous and mental debasement, with no adequate compensation. It attempts by various devices of operative ingenuity to substitute artificial abnormal conditions for natural abnormal ones. Adhesions are alternately broken up and encouraged. The plastic possibilities and opportunities of each and every area are given full play. Theory after theory is advanced and acted upon only in turn to be discarded. Stretched ligaments are given more stretch. Attenuated fibres are made more attenuated by increased stress. Pressure is relieved at one point to be increased at another. The uterus is split in order to destroy its functions, arteries destroyed to interrupt the circulation, and nature madly defied in her efforts to point out the way. The integrity and functions of the local nervous and vascular systems are interfered with. Tissues are misplaced and transported regardless of their normal relationships and impulses, and a state of more or less complete anarchy is induced in the female pelvis. Experiment pure and simple runs riot, and the dictates of physiologic philosophy are insulted.

In this line so-called misplacements of the various organs, and attempts at rectification call for the major portion of attention. There seems to be a no more fruitful field than this for disagreements, misunderstandings and demonstrations.

The classic "falling of the womb," with all its associate disorders, has eternally been synonymous with professional inadequacy, and is but little less humiliating today than a thousand years ago. The ideas of the perpetual motion crank, and of him who would elevate himself by his own boot-straps, have continued largely to govern the treatment of this disorder, or association of disorders. As it was at one time the prerogative of every gynecologist to invent a new pessary or speculum, so is there now no reluctance to accept the responsibility of devising some new operation for misplacement of the uterus. This latter has given even greater variety to the kaleidoscopic features of gynecological progress. Thus far, however, it has eventuated in nothing more stable than the apparent fact that woman must continue to suffer from these uncertain efforts. It may be as well that she suffer with them as without them, but the conclusion is neither pleasing nor satisfying to the scientific and humanitarian mind.

It seems to the writer that in respect to this subject, and as a fundamental starting point, the status of the organs concerned and their attitude under conditions of health are not accurately and vividly understood and asserted. Comparatively few—perhaps none of us—have a proper conception of the normal condition, position and attitude of the female pelvic organs, especially those immediately concerned in the process of generation. The academic diagrammatic out-put in that direction has changed from decade to decade, varying with the observation and reasoning of the individual author. Today the prevailing pictorial illustration represents in the lateral half of a female pelvis a corrugated black line of vaginal closure, into which is nicely fitted the cervix of a well-formed uterus, whose straight and becomingly balanced walls flank an axis at about right angles with the aforesaid vaginal slit. The bladder is neatly folded into a three-cornered, napkin-like parcel and comfortably tucked away in a convenient nook between the pubic arch and the uterus. The ovaries are primly in proper position, and together with their respective tubes are lightly supported in space by something that is

not apparent. They present a beautiful aspect in their freedom from all sorts of encroachment and perversity of demeanor, and as one admires them he is almost tempted to freeze his patient, with her obstreperous organs, and fix them likewise into an eternal calm of normal rectitude.

But in the actuality we find distinctions with corresponding differences. The ideal is lost in the reckless aspects of the real. The faultless conceptions of the dreamer must give place to the variations of the actual.

There need be no great difficulty experienced in securing opportunity for examination of the female pelvic organs under conditions of good general health, such as usually falls to the lot of mortals. Certainly as perfect as any of those from whom "frozen sections" are likely to be obtained.

When one has in a number of instances secured that opportunity, what does he find? A great variety of shapes, sizes and contour of uterus, with infinite variations in condition, position and attitude. What does it all mean? It means that in regard to these features there is not nor can there be any precise fixed and invariable "normal" standard. It means, in fine, that the essential reproductive organs of woman were meant by nature to have and enjoy immense latitude in size, shape, position, movement and development, and that *in so long as they are intrinsically and integrally healthy* almost any variation in position and attitude inside the body is compatible with just claims of well-being. Retro and anteversions and flexions are in themselves not necessarily pathologic conditions, as any wide observer knows, else we should be obliged to consider at least fifty per cent. of women abnormal in structure; in which event the preponderance of testimony would be in favor of our being mistaken in our interpretation of the term "normal." A rule with as many or more exceptions than applications must in the nature of things arouse suspicion as to its accuracy. Again, the mere matter of weight of the uterus ceases to have the same significance when we reflect that in the essentially normal condition of pregnancy that organ so greatly increases in dimensions and ponderosity, without en-

dangering necessarily or usually the functional integrity of adjacent organs and parts. We must realize, of course, that functional compensations are associated with the condition in illustration, but even so, compensatory activities are constantly developed in the human organism in efforts at maintenance of health, and the fact should be taken into consideration in estimating the importance and value of any apparent morbid presentation.

The fact is, in regard to these various "misplacements" and so-called morbid attitudes, that most of them are not in and of themselves disorders, but are disturbing elements only in the sense that they are associated with integral pathological conditions. A retro-verted or flexed uterus, while not a pathologic factor *per se* may readily become one in association with a prolapsed, inflamed ovary, or a diseased rectum, or a pelvic neuritis. Likewise a normally anteverted uterus may become a most distressingly morbid agent in case of a cystitis, or irritable bladder. It is thus apparent that these pathologic imputations are on a merely relative, and not a fixed, basis. Indeed it might be reiterated with little fear of successful contradiction, that the interstitial condition or state, and not the conformation, attitude or position of any of these organs is at the bottom of the diseased manifestations. I have seen women in a state of comfortable health with the uterus and vagina protruding from the body, and others wretchedly miserable with them in place in their approximately orthodox positions. But neither of these observations argue anything but the fact that nutritive and not mechanical disturbances were the essential factor of the morbid impulses.

If this salient position of intrinsic organic nutritive defect as the source of pelvic ill-health, is accepted, it is plainly to be seen that but little of relief can be expected through the innumerable plastic operative procedures, unless done for their direct influence on the meta-morphosis of tissue, and that consequently a not far reaching limitation to them is an obvious necessity.

Fixations and counter-fixations are, in the pelvic cavity illogical, and contrary to both



common and physiologic physics. One operator deems adhesions of any kind anywhere between organs, of pathologic import, and proceeds at every opportunity to break them up, on general principles. Another, under the glittering inspiration of reconstructive ideals proceeds to contract adhesions here, there and everywhere almost, avering that where he wants them to they will linger, while where they are not needed, faith in nature's power of discrimination will be rewarded by a timely absorption and consequent release.

Why not try to free ourselves of the many false notions of mechanical expediency, and study more closely the natural and inevitable limitations of constructive as well as destructive art in connection with gynecology. It will be found that the larger proportion of the local ills of women are due to conditions entirely dissociated from the application of operative surgery. These it is not my purpose at this time to attempt to recount. Suffice it to say regarding them in this connection, that we all have, as before said, constantly brought to notice in our own experience and that of others the most ingenious and surgically successful operations without the least relief to the patient. A circumstance that is as suggestive as it is unsatisfactory and humiliating. Indicative of the fact that in our zeal for doing something radical we have overlooked the more subtle, but essential, nature of the disorder.

As before hinted, where operative interference can justly be counted to best assist in restoring mechanical and vital equilibrium it is always and surely indicated, but its application should be limited to such a consummation. The removal of deleterious products, be they distinctly abnormal growths, hypertrophies or degenerative debris, is a justifiable act of ablative surgery, in response to the protective demands of normal nutritive effort. Even complete denudation may be justifiable when destructive disorder is co-extensive with the reproductive organs involved. But that is a very different thing from the transposition of tissue relationships which characterizes in so large a measure the efforts in what I

have called the field of reconstructive, or more properly perhaps, re-adjustive work.

A tissue which has lost its *tone* cannot be restored by any process of elimination nor by any process of re-duplication. The more the tension on it is increased the greater and surer its final devitalization, destruction and physiological collapse. Abbreviations of ligaments, of fascia, of membranes and skin, as well as doubling and folding of them, all smack of useless subterfuge. They are but make-shifts, and in the very nature of organic plasticity can be of but temporary value at best. The stream cannot be maintained at a higher level than its fountain. Normal elasticity of tissue cannot be restored by such means, and mere increase in bulk is no assurance of strength, and can avail a good purpose only where padding is a desirable adjunct. No mere anatomical rearrangement can satisfy functional demands, no artificial cajolery excuse a faith in abnormal substitutes. There must be taken into account not only the grosser manifestations of disorder, locally speaking, but those finer, more ultimate activities of tissue metabolism upon which the former depend, and especially the neural relationships, both motor and sensory, in their actions and reactions both local and general. It is this complex of influences of which so little is known and to which so little attention is given, that foils so often the therapeutic prognosis. Often the operative specialist is a diagnostic failure. His knowledge of general physiology is either limited or neglected, his training along neurologic lines is defective, and he sees mainly the possibilities of his art in a direct sense. He does not see, what is so often the case, that neurotic displeasure and not structural or positional defect is at the bottom of pelvic pains and distresses, and that there are many conservative means far removed from destructive intervention which will accomplish a better purpose.

The whole energy of professional endeavor, in a large proportion of these cases, needs be in the direction of securing *stability of fibre* through improved circumstances and processes of general and local nutrition, rather than in mutilating inter-

ference with anatomical arrangement. For the former there is no direct substitute in the arts of man. His mechanism may be perfect in its way, but it lacks the element of responsiveness to its own needs. All acceptable endeavor must be through nature's own channels. The therapeutics of the future must probably deal more and more with substances derived from the animal body, and while we know little as yet of the nature of the actions and reactions within the economy, we do know from practical observation of many circumstances favoring their proper routine development in connection with nutrition, and should look more to such aid in the restoration and maintenance of function, than to various interruptions of continuity yet more ambiguous in their tendency. It must have in view such encouragement to normal nutrition as will meet physiological demands Food, digestion; mechanical, chemical and electrical stimulation, both general and local.

That surgery can be made further available in that direction is doubtful. If by any maneuver of it, nerve tissue can be made to respond to the vital demands upon it, muscular fibre be increased in quantity or improved in quality, connective tissue multiplied and stored with fat, and vascular tone and energy be made responsive to the demands, then its mission has only begun. If not, its practical limits have been reached in the sphere of gynecology, and must be further narrowed with each succeeding decade, until "occasional enucleation" and "repair" alone remain its watch-words.

#### Discussion.

**T. J. Watkins, of Chicago:** Mr. President.—I believe that this beautiful word picture, this timely paper, should not go by without some discussion. I am very glad that Dr. Will spoke against operating on cystic ovaries. It would seem that there is no excuse for gynecologists treating sclerocystic ovaries until the pathologists have given us more definite ideas as to the real nature of the trouble, or, in other words, until they have determined it is a pathologic and not a physiologic condition. I believe I never see a case that suffers from sclerosis of the ovary, or from sclero-cystic degeneration of the ovaries, not including normal ovarian cysts, and I hope the time will soon come when there will be less attention paid to displacements of the uterus, as Dr. Will has indicated in his paper. The subject of anteversion should

not receive any attention in any of the text books, because there is no such thing as a pathologic anteversion. One almost never sees cases of pathologic anteversion, and, as the Doctor says, very few cases of backward displacement of the uterus cause any trouble unless there has been an infection of the ovaries and tubes, and one is very seldom called upon to treat cases of backward displacement where there has not been salpingitis and oovaritis.

I agree with what he has said regarding laceration of the perineum. The fact that a woman has some tear of the perineum is no indication in a gynecologic sense for an operation. What he said about laceration of the cervix is likewise true. Almost every woman, who has had a child, has had a laceration of the cervix, and very few of them require an operation. It is a physiologic, and not a pathologic, condition. There are two indications which we should bear in mind, one is erosion, and the other marked cystic degeneration.

**S. C. Stremmel of Macomb:** I do not feel like permitting some of the statements made by the essayist to go by unchallenged. I have done a great deal of gynecologic work, and while some of my results have not been as satisfactory as I have anticipated and expected, that is, in some cases, I am convinced that some of the surgical procedures which the doctor deprecates are eligible operations and should be continued to be done. I do not believe it would be the consensus of the leading surgeons all over the world to keep on doing these operations for years and years if there were nothing to them. Mal positions of the uterus are in themselves a source of discomfort, sufficient in many instances to incapacitate women from doing hard work, and we have a deleterious effect produced from many of these lacerations, and I am convinced from my own experience that a great deal of good has been accomplished by timely and well planned operations. I would like to show the doctor some patients upon whom I have operated for displacements of the uterus and for cystic ovaries, so that he might get a clear idea of the state of their health before operation and at the present time. These things are so, and to deplore the matter on the ground that a few of us do too much operating, possibly in unselected cases, I don't believe is right.

**Dr. Will (closing the discussion):** I have no desire to discuss the matter any further, except to remove some misapprehensions. In the first place, I do not wish to be understood as claiming to avoid the repair of lacerations, but I distinctly stated that the indications for repair were not always present. The extent of the laceration should indicate the extent of the operation for repair. Understand me, I am not condemning operative procedures; I am condemning the utilization of operative procedures where they are not necessary, and I know they are not in a great many cases in which they are done at all necessary, because they do not accomplish anything. When we have experimented a little and have found out that an operation does no good, it seems to me we should not continue doing it indefinitely when it is contrary to all physiologic sense. I



have done a great deal of operating from time to time myself, but my claim is that we should be conservative along these lines, and not be eternally operating for the sake of doing so and simply for the sake of blinding one's self to correct diagnosis.

## PROCEEDINGS OF STATE SOCIETY.

Minutes of the Fifty-Second Annual Meeting held at Quincy May 20-22, 1902.

The report of the Judicial Council was next in order, and was read by J. F. Percy.

### **Report of the Judicial Council.**

*Mr. President and Members of the Illinois State Medical Society:*

But one subject for our care and consideration was reported to us by the general society at its meeting in Peoria. This was embodied in the following resolution: "Resolved: That the Judicial Council select some member of the Society to act as Editor and Manager of the Journal; said Editor and Manager to be paid a reasonable amount of salary to be determined by the Judicial Council."

The report of the Editor as to his management of the Journal will come before the Society through Chairman Cook of the Judicial Council.

Whatever else we have done aside from the above matter of the conduct of the Illinois State Medical Journal, since the Peoria meeting of our Society, has been but a reflection of the recommendation given us at the Springfield meeting of the Society in 1900, where we were instructed to see what we could do in the way of influencing the appointment of the best qualified medical men and women to the positions of responsibility in the State institutions, where the services of physicians were required. Whatever we may have attempted this year without direct instructions from the Society, whose servants we are, nothing was done in this or any other matter without mature consideration, either on the part of the Council as a body, or of its Executive Committee.

You will remember that the resolution above referred to, read as follows: "That the Judicial Council of the Illinois State Medical Society be authorized to present to the Governor a list of physicians eligible to ap-

pointment on the State Board of Health and to all other offices in the State to which physicians are usually appointed by the Governor. The Judicial Council to be guided in their recommendations by suggestions of local medical societies in good standing." When the Judicial Council was instructed by this Society to take an interest in the political appointment of physicians to the State eleemosynary institutions, it was probably not divined by the Society that the entire field of political appointments must necessarily be the subject of their consideration. We learned that mere recommendations would be ignored with respectful contempt. We were soon made aware of another thing, and it was, that the average politician only respects organized bodies of voters who are looking after the fulfillment of the demands that they may have made on the political powers of the State. The Council then, was in the position where it was either to make its recommendations as directed and then fall back into a position of indolent complaisance, or on the other hand, to use all honorable means to see at least that its recommendations were respectfully considered. This last was the course finally chosen. And it was done mainly because we assumed, of our own knowledge, that the great body which we represent, had been too long derelict to its duty toward the wards of our State Institutions, in that we had not demanded for them the best that our profession had to offer. Again, we could not help but feel that the matter referred to us in the recommendation above quoted, was but the synchronized voice of the profession of this great State, beginning to demand that it be recognized in these matters which so vitally appeal to its usefulness and power. It is to be regretted that there is no accurate means of knowing just how much good the passing of the above resolution by the State Society has had on the profession as a body, throughout the State. We do know, however, of the many instances where physicians have been moved to join the Central Society in order to be in touch with whatever good might come in the future through any action that this Society might take, because of its more perfect organization. This has been



espeecially true of those who were looking for positions under the State government.

It has been a question in the mind of every member of the Judicial Council just how far it should or could go, under the Springfield resolution of 1900. The Council has ever had before it, the realization of the fact that the work that it was doing along these lines was in the nature of an experiment. That we had no precedents to guide us. The question has been debated at our meetings as to whether it would not be wise to recommend to the Society that a new committee be formed for the purpose of looking after the political affairs in the State which are of interest to the medical profession as a whole. But nothing definite or tangible has been done with this suggestion in the way of authorizing the presentation of this as a recommendation from the Judicial Council. At one time it appeared to us that it was pre-eminently the work of the Legislative Committee, but Chairman Black of that committee has well pointed out that for his committee to take up such work, must of necessity at times bring them in conflict with a successful politician for whose defeat they had left no stone unturned. Assuredly then, it would not do to subject this very important committee to the possibility of embarrassments of this kind. A case in point, is the one now pending in the thirty-second senatorial district of this State where Ex-Senator O. F. Berry, who championed during his term a bill that was very objectionable to the whole profession of this State, is seeking re-election. This is the bill that was fortunately vetoed by the late Governor John R. Tanner. The original bill for which the Ex-Senator above referred to, stood sponsor, would have thrown the State wide open, without any legal control whatever, to any and all kinds of quackery, no matter how preposterous. Essentially, all that this bill required, was, that such individual or individuals should claim that they were practicing medicine under the methods permitted in the bill. The championship of this bill was persisted in, in spite of the formal protest of many of the physicians in this Senator's district. No attention, however, was paid to these objec-

tions by the Ex-Senator who is now seeking re-election.

In the early part of January of this year, one of the physicians in Ex-Senator Berry's district and of the same political faith with him, wrote to C. B. Horrell, Secretary of the Military Tract Medical Association, detailing what has been written above and inquiring not only for the doctor's personal influence to defeat the nomination, or if that was not successful, the election of Ex-Senator Berry who was seeking re-election. Dr. Horrell turned the correspondence over to the secretary of the Judicial Council by whom it was transmitted to every member of the Council. The secretary was then instructed to communicate with the Ex-Senator as to his past and prospective attitude in case of his election, toward the medical profession. The Senator's reply was so frank and apparently open, that when it was communicated to the members of the Council, the secretary was instructed to write Mr. Senator and congratulate him on his interest in and work for scientific medicine. Before doing this, however, the secretary of the Council communicated with some of those who were members of the State Board of Health at the time when this matter was before Governor Tanner. The information derived from this source put an entirely different aspect on the Ex-Senator's relationship to the measure in question. Suffice it to say, that he was, while serving as a Senator, accepting fees, to push measures for the undoing of the medical profession through the Senate of this State. Our relationship as a Judicial Council to this matter was discussed at a meeting of the Executive Committee of the Council held in Galesburg, January last. Later, the matter was fully discussed at a meeting of the Judicial Council, held in the Great Northern Hotel, Chicago, April 3d of this year. At that meeting, every member of the Council was present and the unanimous opinion of the members was, that if the State Medical Society ever had a legitimate right to go into politics, it was in a matter of this kind, which so vitally concerned the profession of this State.

In April, the secretary of the Council was invited by the Monmouth Physicians' Club,

to meet with and discuss with them the practical political side of this question. As a result of that conference, the following resolution was adopted:

*Resolved:* That the Monmouth Physicians' Club at its regular annual meeting, held in the city of Monmouth, April 4, 1902, does protest against the nomination of O. F. Berry of Carthage, Ill., to fill the office of Senator from the 32d Senatorial district.

The reasons: His record while in the Illinois Senate in 1897, on matters relating to rational and scientific medicine was such as to fail of commendation by the members of the Monmouth Physicians' Club. In the event of his nomination at the convention to be held at Macomb, we will use every honorable means in our power to prevent his election to the high office to which he aspires." (Signed.) W. H. Wells, Secretary.

The Secretary of the Council was also invited to address the Warren County Medical Society at its annual meeting held in the city of Monmouth, May 3d. As a result, the same resolution as that previously acted upon by the Monmouth Physicians' Club, was adopted with but one dissenting voice.

The thirty-second Senatorial district comprises the counties of Warren, Hancock and McDonough. The above action, therefore, of the Warren County physicians was most significant. The Council was also asked to present this matter to the Hancock County Medical Society through the secretary of the Council. This was done at the annual meeting of the Society held at Carthage, May 5th last. An interesting political status was found to obtain in this county which was well brought out at this meeting of the physicians. Of the ten men who were present, all were Democrats but two, and the secretary of the Society is authority for the statement that the same relative proportion obtains throughout the county, viz: Eight Democrats to two Republicans. After a splendid debate in which the general welfare of the profession as a body, was ably discussed, it was decided not to commit the Society formally against the candidacy of Ex-Senator Berry for re-election. The reason given was, that the large majority of the membership being Democrats, any action that they might take

as Democrats, would but aid the Senator in his contest.

In brief, this is one part of our report. It is given that you may see and realize that the Illinois State Medical Society must consider at this session, or at least, at a not very far distant session, its relationship to the political powers of the State. And to make this effective, some method should be devised by which a responsible committee can act for the Society in the interval between the annual meetings.

In our report of last year, we referred to this matter in the following words: "If it is the purpose of the State Society to aid the administrative powers of the State in the future in the selection of men and women in every way best qualified to fill the positions to be filled, in other words, to go into politics, it is absolutely necessary, in order not to fail, to have the intelligent co-operation of every medical man and woman in every medical organization in the State. To do less than this is to invite failure of a most hurtful character, and to fail now will put us back many years, and that, too, in a most humiliating way." We deem this a matter of great importance, and respectfully call the Society's attention to it again.

At a meeting of the Council held in the early part of last October, the above matter was fully discussed, especially by the older members of the Society, who are also members of the Judicial Council. The fact was well brought out at that conference, especially by Dr. Mitchell of Carbondale, that the conditions for political appointment have changed and we must devise plans to meet the emergency. We know that the politicians have placed our State Executives under vastly more obligations to them than have the physicians, and until we can do likewise, we need not expect to control much of the political patronage. Dr. Mitchell made the further point at that meeting, that the physician who thinks it is beneath his dignity to go into politics is unworthy of the name *American Citizen*. Continuing, the doctor said: that the Council had sowed the seed of our political edifice and that if we can only push forward in the right direction, we will in the future become a political power

and can have something to say relative to the appointment of our *best* medical men to positions in our State institutions. As to the best method for accomplishing this, the doctor suggested the following: In the political organization of our State we have what we call a State Central Committee, consisting of a certain number of gentlemen from every congressional district in the State, and we have a County Central Committee, in every county. He stated that his plan would be to have in this State Society, a committee that would be to the State Medical Association, what the State Central Committee is to the State political organization. The members of this committee should be distributed over every portion of the State. Now give to each member of that committee, a district consisting of a certain number of counties. Let each member organize the physicians in his district and have them see that at least one physician is appointed on every county central committee, both Democratic and Republican. Urge these committeemen to attend every political caucus and meeting, spend time, and money too, if necessary, and in addition, make himself generally useful to the committee during the entire campaign and thus aid in every honorable way possible, to carry the election. When the campaign closes, we shall then have the political machine under obligations to us; and then, and not until then, can we have a voice in the State appointments as is justly our due.

One more word along this line and this part of our report will be left for the consideration of your best judgment and advice. It is this: We have not accomplished all we had hoped for when the Society in 1900, instructed us to look after the appointment of physicians to the State charitable institutions; but in several important particulars we have received recognition never before accorded any body of medical men in this State. First; your Judicial Council has been granted on several occasions, an official audience with Governor Yates, as the representatives of the medical profession of Illinois. He has recognized us by his correspondence. Second; he has based his State Board of Health membership on the mem-

bership of the Illinois State Medical Society. Third; he has refused to appoint, in two instances at least, physicians who were slated for important positions under the State government, when the Judicial Council protested against such an appointment, because of the general lack of qualifications on the part of those about to be appointed. In one of these instances, the personal correspondence between the Governor and the Council was short, sharp and to the point. The Governor contended that his prospective appointee was all right and asked for proof to the contrary. This was promptly furnished. Result: The appointment was not made. We also regret to say (and this without discreditable reflection) that in several equally important instances, he has taken a different view from that expressed by the Council. We have reason to believe that in one or more of these instances, he has reason to regret that he did not accept such suggestions, but this should not give us liberty to impugn his motives.

It is to be hoped that this side of the life of the State Society which has been so prominently brought out in this report, will not blind us to the fact that the State Medical Society is, or should be, first of all, a scientific body. But in extenuation for the prominence given to the purely business or executive life of our organization, it must be remembered that the Judicial Council is the materialistic side of the Illinois State Medical Society.

During this year, five new medical organizations have sought to affiliate with this Society. All but one were found to be based upon a constitution and by-laws in harmony with the aims and objects of this organization, and Permanent Secretary Weis was instructed to admit all but the one above mentioned.

In closing, we beg leave to repeat here the words that were used to close our report of last year.

"Our chief duty then would seem to be, to maintain our organization at the highest possible point of efficiency; first, as a scientific body, and as a very close second, a comprehensive business association. Any other combination of aims will not secure for us



the respectful hearing that the interests we represent, require. Only such an organization will arrest the attention of the politician and at the same time maintain in the profession, that standard of dignity, and among the people, that modicum of respect so essential to the highest efficiency."

J. F. Percy, Sec. E. P. Cook, Chrm.

JAMES H. STOWELL: I move that the report of the Judicial Council be accepted.

J. W. PETTIT: I rise to second the motion, and, in doing so, I wish to say that more than a formal acceptance of this report ought to be made by the Society. The report of this Committee shows not only the wisdom of our action in referring medico-political matters to the Committee, but they have been placed in safe hands. I think an amendment ought to be made to the report, namely, that it not only be accepted, but that a Committee be appointed to take such action as may be deemed proper to put in proper shape the recommendation of the Committee for practical adoption. The report is an excellent one. It shows remarkable progress, progress which two years ago I could not have believed could have been made in such a short time. It shows we are working on right lines, and if such work continues in the future, it will make us a power, as we ought to be.

HAROLD N. MOYER: I wish to offer an amendment to Dr. Pettit's motion, but before doing so I want to say, that this report of the Judicial Council simply shows where the profession is standing now. There is no reason why the medical profession can not only be a scientific and social body, but, when it is properly organized, it can become a politically effective body, not on selfish, narrow lines, but on broad lines, for the public and professional good, for what is good for this profession is likewise good for the public. They are fortunately synonymous.

In reference to the report and the appointment of a special committee, we adopted a new Constitution and By-Laws, which means the formation of a representative body from every county in the State, with power to act, virtually separating the business of the So-

ciety from the scientific part of this body. I make the suggestion, without making a formal motion, would it not be better to divide the report, and refer that part which deals with political matters to the House of Delegates, which is to be formed next year?

J. W. PETTIT: I accept that suggestion as an amendment.

DANIEL R. BROWER: I do not see why this important matter should be deferred for one year. The motion before us really postpones action upon the whole question for one year, as I understand it. Is not that the case, Mr. President?

THE PRESIDENT: Yes.

DR. BROWER: I am opposed to this matter being postponed. Permit me to say, that the legislature meets the coming fall, and it does not meet again for two years.

DR. PETTIT: The Chairman of the Legislative Committee, Dr. Ingals, objects to the present motion. He is very modest, but I insist that he ought to say something. The matter is very important, and should be acted upon now. If that is Dr. Ingals' judgment, I yield to it.

DR. MOYER: I will withdraw my motion.

JOSEPH ROBBINS: We ought to move in this matter with caution instead of precipitancy. It is a grave question when we convert, even in part, this body into a political machine from work that ought to be done. Good work has been done by the Judicial Council, and more of the same kind ought to be done; but whether the Illinois State Medical Society shall enter the field as an avowed political factor is a question. I hope we shall move in this direction with great caution.

DR. PETTIT: It seems to me there ought to be a separate motion made for the adoption of the report of the Committee, then a subsequent one made with reference to medico-political matters.

I move that we accept the report of the Committee. Seconded and carried.

JOSEPH ROBBINS: I now move that the subject-matter of a medico-political character be referred to a committee of five, to report at this session, the committee to be appointed by the Chair. Seconded and carried.

# The Illinois Medical Journal.

The Official Organ of the State Medical Society.

EDITOR—George N. Kreider, A. M., M. D., Springfield.

Official Reporters of Affiliated Societies—

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Fox River Valley—H. J. Gahagan, M. D., Elgin.  
Military Tract—C. B. Horrell, M. D., Galesburg.  
North Central—Geo. A. Dicus, M. D., Streator.  
Southern Illinois—O. B. Ormsby, M. D., Murphysboro.  
Tri-County—Leroy Jones, M. D., Hoopston.

## URBAN SOCIETIES, EX CHICAGO.

Alton Medical Society—Geo. E. Wilkinson, M. D., Alton.  
Aux Plaines Medical—W. R. Livingston, M. D., Maywood.  
Decatur Medical—Lynn M. Barnes, M. D.  
East St. Louis—C. W. Lillie, M. D.  
Jacksonville Physician's Club—D. W. Reid, M. D.  
Peoria Medical—E. M. Eckard, M. D.

Marshall County—  
Massac County—C. E. Trovillion, M. D., Metropolis.  
Mercer County—A. N. Mackey, M. D., Aledo.  
Montgomery County—J. M. Trigg, M. D., Farmersville.  
Morgan County—T. A. Wakely, M. D., Jacksonville.  
Knox County—G. S. Brown, M. D., Galesburg.  
Ogle County—H. A. Mix, M. D., Oregon.  
Perry County—J. W. Smith, M. D., Pinckneyville.  
Pike County—R. H. Main, M. D., Barry.  
Pope County—W. S. Dixon, M. D., Rosebud.  
Pulaski County—Chas. J. Boswell, M. D., Beechwood.  
Randolph County—H. C. Adderly, M. D., Chester.  
Richland County—M. E. Poland, M. D., Olney.  
Saline County—J. R. Baker, M. D., Harrisburg.  
Sangamon County—P. L. Taylor, M. D., Springfield.  
Schuyler County—A. W. Ball, M. D., Rushville.  
Shelby County—A. G. Mizell, M. D., Shelbyville.  
Stark County—M. T. Ward, M. D., Toulon.  
Stephenson County—R. J. Burns, M. D., Freeport.  
St. Clair County—B. Portuondo, M. D., Belleville.  
Tazewell County—C. G. Muehlman, M. D., Pekin.  
Union County—T. Lee Agnew, M. D., Anna.  
Vermilion County—E. E. Clark, M. D., Danville.  
Wabash County—J. B. Maxwell, M. D., Mt. Carmel.  
Warren County—W. H. Wells, M. D., Monmouth.  
White County—W. A. Steele, M. D., Carmi.  
Will County—Herbert S. Worthley, M. D., Joliet.  
Williamson County—G. W. Evans, M. D., Marion.  
Winnebago County—S. R. Catlin, M. D., Rockford.

## CHICAGO SOCIETIES.

Academy of Medicine—J. G. Kiernan, M. D.  
Electro-Medical—Richard H. Street, M. D.  
German—Karl Doepfner, M. D.  
Gynecological—C. S. Bacon, M. D.  
Medical Society—F. X. Walls, M. D.  
Medico Legal—N. S. Davis, Jr. M. D.  
Neurological—C. H. Lodor, M. D.  
Ophthalmic and Otological—Brown Pusey, M. D.  
Orthopedic—Edwin W. Ryerson, M. D.  
Pathological—Geo. H. Weaver, M. D.  
Pediatric—Emma M. Moore, M. D.  
Physician's Club—L. H. Mettler, M. D.  
Laryngological and Climatological—J. E. Rhodes, M. D.  
Rush College—J. B. Herrick, M. D.  
Society of Internal Medicine—Robt. B. Preble, M. D.  
Southwestern—Thos. J. McGonagle, M. D.  
West—Gustavus M. Blech, M. D.

All communications should be addressed to the Editor, 522 Capitol Ave., Springfield, Illinois.

The Society does not assume responsibility for any statements or opinions published in the JOURNAL.

The JOURNAL is published monthly. The subscription price is \$3.00 per annum in advance. The JOURNAL is furnished free to the members of the Society.

Entered at the postoffice in Springfield as second class matter.

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OCTOBER 1902.

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## THE STATE SOCIETY AND MEDICAL LEGISLATION.

The State Medical Society at the Peoria meeting last year committed itself unequivocally to the problem of securing substantial changes and betterments in the act regulating the practice of medicine in Illinois. It is undoubtedly true and the better elements of the profession recognize the fact that Illinois once the leader in all that tends to the uplifting of professional standards has

fallen behind in the procession. The present law has been found fatally defective by the courts. True the conditions are not quite so bad as they appeared last year, but still there is no question of the necessity of a new act. In this great undertaking there must be a practical unanimity among our members to begin with. Then the provisions of the act finally decided on, must be so just and reasonable that no antagonism will be excited among the honorable members of

other schools and sects. They should and probably will be equally interested with us in securing more perfect legislation.

On the other hand there will be antagonistic elements at work, whose influence should not be underestimated. In any battle it is a safe plan not to underestimate the strength of the enemy. A certain magnetic healer of Ottawa has addressed letters to his fellows throughout the state, calling on them to co-operate with him in having the present law repealed. The venerable T. A. Bland, chief promoter of the National Medical Union is still on earth. He has an abundance of time and apparently a quantity of money to push his canvas in advocacy of a condition like to that which prevailed prior to the civil war. That is free trade in practice and the giving of diplomas. The Christian Scientists and Dowie, the osteopaths and the anti-vaccinationists will be on hand with their cry of persecution. Altogether the Society and its committee will have work to do. They will need money with which to accomplish this herculean task. We trust our members will not fail when it comes to active labor and liberal contributions. Let us all unite to secure for Illinois the best act regulating the practice of medicine to be found on any statute book. We can secure it if we will.

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#### CHRONIC SEROSITIS.

In the lymphatic channels, obstruction takes place easily and the propagation of morbid processes in a direction which is the reverse of that ordinarily taken by the fluids circulating in them, is known to occur frequently in a number of diseases. The disposition of the lymph channels on each side of the diaphragm is such that affections on either side are often manifest, to some degree, upon the opposite side also. In

the lymphatic glands of the anterior mediastinum currents of lymph enter from both the pleurae and the upper surface of the liver; into the glands about the oesophagus lymph is received from the surface of the left hepatic lobe.

By these routes a variety of diseases are subject to transportation from one serous cavity to another. Gynecologists have long been familiar with the incidence of pleuritis on the right side in cases of peritonitis, especially puerperal peritonitis. Tubercles on the surface of the liver and spleen and adhesions between these viscera and the diaphragm are very common in chronic tuberculosis of the pleura: carcinoma, also, may extend along the lymph channels, through the diaphragm.

In exceptional cases of combined and chronic inflammation of the pleura, pericardium and peritoneum—in other words, of chronic serositis—the viscera contained in these sacs are firmly joined to their enveloping membranes and to the diaphragm. Usually the adhesions are more marked upon one side of the diaphragm than the other and the corresponding serosa is the seat of the greatest thickening; of the viscera in the peritoneum, as a rule, only those just below the diaphragm are involved. Thus with an adhesive pericarditis of long standing which leads to obliteration of the cavity and which is often the seat of an extensive deposit of lime salts, there may develop chronic pleuritis, indurative mediastinitis, perisplenitis and perihepatitis. Likewise with chronic peritonitis situated just below the diaphragm, the pericardium and pleurae may be found—in necropsies—in some degree, the seat of adhesions.

Although well marked instances of chronic serositis are rare, they compensate in interesting features for their scarcity. Their proper clinical interpretation is always dif-



ficult and the unravelling of the chain of events may be at times, impossible even in post-mortem examinations on account of the long duration of the process, which may have been a matter of years and by reason of the locking together of the contiguous supra and sub-phrenic structures with firm thick layers of scar tissue. The "frosted" or "icing" appearance of the liver, in these cases led Curschmann to apply the name "Zuckergussleber" to the chronic productive perihepatitis. The unfortunate title "Pericarditic Pseudo-Cirrhosis" given by Pick to a group of symptoms due to adhesive pericarditis and impeded heart action has led to considerable controversy.

In a recent monograph upon this subject Nicholls (1) has undertaken to disentangle some of the questions at issue. In latent adhesive pericarditis, there often occurs a perihepatitis which Pick claimed was a result of the interference with the circulation and he even attempted to account for the "Zuckergussleber" of Curschmann in the same manner.

There are very good reasons for believing that the explanation offered by Pick is not the true one, and the consideration by Nicholls of this phase of the subject is but an echo to the conclusions of others who have discussed it and reported cases (Rumpf, Siegert, Schmalz and Weber). The most reasonable view of the etiology, is that from an acute serositis beginning upon one side of the diaphragm, the adjacent serous membranes become affected and the conditions left by partial or more perfect healing of the acute process produce the morbid changes under discussion. The chronic productive perihepatitis—"Zuckergussleber"—may be primarily subphrenic or it may result from

the regional invasion of an inflammation primarily located, as regards the serous membranes, in the pericardium. It is shown by Nicholls that the order of frequency with which these adjacent serous membranes are conjointly affected, is the same for the chronic conditions as is known to obtain in acute multiple serositis. In the majority of cases that become chronic, the history points to primary involvement of the peritoneum, with extension to the pleura and pericardium; in some instances the primary lesions have been in the thorax from which extension to the peritoneum has produced a chronic hyperplastic perihepatitis or perisplenitis. The age at which these cases of chronic serositis have been encountered is in accord with the healing of acute inflammations of the various serosae—acute polyoromenitis—that are known prevail between the ages of 16 and 30 years. The characteristics of the ascitic fluid, so far as it has been examined, are those of an inflammatory exudate and the membrane that forms around the viscera, a layer that is sometimes as thick as the thumb and of a cartilagenous consistency, is clearly an inflammatory product.

Nicholls reports two new cases of this order; in one the onset of the trouble seems to have been a round ulcer of the duodenum; in the other an unresolved pneumonia on the right side was accompanied by "zuckerguss" spleen. Packard (2) has observed one case resembling the latter. The instance recorded by Schmalz and Weber is extremely interesting in showing how the different serosae may be successively involved; an appendicitis and perityphlitis led to chronic peritonitis and "Zuckergussleber" and at the necropsy there were found in addition,

(1.) A. G. Nicholls, a somewhat rare form of chronic inflammation of the serous membranes (Multiple Progressive Hyaloseritis).

Studies from the royal Victoria Hospital, Montreal. 1902, I. No. 3, (April).

(2.) F. R. Packard, extreme cirrhosis of the liver with ascites and perisplenitis.

Proceedings of the Philadelphia Pathological Society, 1900.

chronic adhesive pleuritis on the left side and an *acute* fibrinous pericarditis. Herrick (3) has lately reported a case in which all three serous membranes were involved, the process starting evidently in the pleura and the pericardial exudate being extensively calcified.

It is apparent that there are two chief points upon which the well-known work of Pick is open to criticism. One of these, already mentioned, was in attributing the perihepatitis in these cases to a disturbance of the circulation; the other, the use of the term pseudo-cirrhosis, for in many of these cases a cirrhosis has been found. Wells has pointed out that the liver as a rule, is cirrhotic in cases of calcified pericardium. However as Herrick has well stated Pick is entitled to great credit since interest in this subject can be said to have taken origin from his original publication in 1896.

#### AMERICAN MEDICAL JOURNALS.

The reception given to our editorial discussion of American Medical Journals in the August issue has been most encouraging. Several contemporaries have taken up the matter and while all do not agree with us in all particulars an interest has been aroused on the subject which may have an important influence in the future.

\* \* \* \* \*

We are pleased to know that the editor of a certain publication at once dispatched an agent to ascertain the sentiment of the profession of Illinois towards his journal. This agent rendered us the highest praise when he stated that the Illinois Medical Journal was the worst enemy of the journal in question. We have every reason to believe that the agent has found a great many physicians in this State who hold the sentiments we expressed editorially and that the

better class of men everywhere has no sympathy with any publication which antagonizes the use of antitoxin and vaccine and which seeks to create a sentiment against vivisection when employed for scientific purposes. Such a publication may have circulation for a time among the half educated and prejudiced, but the day is rapidly approaching when a medical body properly educated to the last man will force the discontinuance of the publication of all such sentiments.

\* \* \* \* \*

Our friend, Editor Alfred S. Burdick of the Medical Standard takes up this subject in his issue of September 15. He discusses the subject statistically along the same lines as our editorial and in addition gives quite a historical review and furnishes a *fac simile* of the title page of the first Boston Medical and Surgical Journal, dating from 1828. He discusses the subject *in extenso* in a very interesting manner and finds, in our editorial, language which he thinks would seem to indicate our desire that all journals not representing societies should be abolished. Whatever our language we certainly had no intention of decapitating all the able editors or sweeping away all the independent journals. No doubt independent journals will continue to exist and no doubt their character will be improved by the high standard set them by those journals directly representing and accountable to the professional organizations. We placed the Medical Standard among the high class journals and are therefore somewhat surprised that its editor appears to give a quasi endorsement to the so-called "popular" ones having the largest (they allege) circulation, which devote most space to details of diagnosis and treatment which are disdained by the more "scientific." Our observation is that these journals utterly fail as teachers of sound

(3.) J. B. Herrick, Pericarditic Pseudo-Cirrhosis of the Liver. Trans. Path. Soc. (Chicago), 1902, V. 71; also Chic. Med. Recorder, 1902, XXIII, 177.

doctrine and leaders of truthful scientific thought. Their influence is given to the contradiction of modern scientific ideas almost universally approved and to the exploitation of remedies in which the editor has some sort of an interest. Representatives of a scientific and honorable profession should, we think, ever and always condemn such journalistic tendencies. Their present popularity proves nothing. It is all the more reason for deploring the misuse of professional publications. However, we quite agree with Dr. Burdick that no journal unless edited with great care can maintain a standing in this day of the survival of the fittest.

The language of the Medical Standard is as follows:

An interesting tendency is found in the recent establishment of medical journals by various state medical societies, to replace the annual volume of "Proceedings." These journals are, in the main, the result of the movement for reorganization and unification with local societies, which they are expected to facilitate. In a recent editorial the Illinois Medical Journal predicts "that medical journalism in the near future will be altogether in their hands." This savors a little of philistinism—of a get-off-the-earth pronunciamento by those who assume to dictate an ethical conception vouchsafed them alone, and to know what is best for journal readers whether they like it or not. The Standard heartily approves of any proper effort to organize the profession, but the mere printing of scientific transactions and of papers of widely varying merit and readableness, such as are read at our annual gatherings, does not constitute journalism, even though every paper should contain matter of the utmost intrinsic value. It is in the selection of articles to meet the tastes of a majority of possible readers—the presentation of the new, the practical and the valuable in the most attractive and readable form that real journalism consists. Artificial support may maintain the official organ, but will not popularize it. To monopolize medical journalism, these journals must enter the open field of competition and prove their claim, not only to superiority, but their right to popularity. In this connection it may not be improper to point out that the journals having the largest circulation are the so-called "popular" ones, which devote the most space to details of diagnosis and treatment which are disdained by the more "scientific."

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Editor Koenig of the Pennsylvania Medical Journal considers this subject editorially

in his September issue from which we make the following extracts:

When it was decided at Pittsburg, in June, 1897, to publish the transactions of the Pennsylvania Society in journal form, some doubt was expressed by various conservative members as to the wisdom of the course. The experience of five years, however, we believe to have amply justified that course in every respect, if the steady growth of the membership and the interest in county societies may be accepted as evidence.

The next Society after that of Pennsylvania to publish its transactions in journal form was that of Illinois. Through the influence of that journal the medical profession of Illinois has grown into one organization of 3,650, from a nucleus of 450. The journal of that association is published on the same ethical principles that govern our journal. Its ethical influence for good cannot be overestimated.

The fact that state medical journals can exist without the aid of the quack medicine manufacturer being now fully established, may we not hope that the board of trustees of the American Medical Association may, in the near future, see the wisdom of purging the advertising pages of its journal of all advertisements that offend the spirit of the Code of Ethics.

During the past year no sample copies of this journal were sent out, except on request, and these even have not all been granted, for it is evident from long experience in this line, that there are not a few physicians who, instead of subscribing to a medical journal, invest the money in postal cards, by means of which they hope to obtain larger returns in the form of reading matter—though of a varied nature—than would be possible were they to expend the same amount of money in payment of the subscription of one journal.

In keeping with the rules adopted at the time of the establishment of the Pennsylvania Journal, the advertising pages have been kept absolutely free from all advertisements of proprietary or trade-marked medicines.

\* \* \* \* \*

In our previous articles we neglected to mention another official journal of a Society, the Journal of the Association of Military Surgeons of the United States, edited by Major Pilcher of Carlisle, Pa. This has recently become a monthly publication and is conducted on strictly ethical lines.

\* \* \* \* \*

It appears that still another Society has recently taken up the journal idea. The Medical Book News is our authority for the statement that the Washington Medical Annals is the title of a new medical journal,



the official organ of the Medical Society of the District of Columbia.

\* \* \* \* \*

Up to the present time the list of journals, official organs of societies, comprises:

- (1.) The Journal of the A. M. A.
- (2.) Six state societies counting the District of Columbia as a state.
- (3.) Four county societies.
- (4.) The Military Surgeons of the United States.
- (5.) The American Academy of Medicine.

In all thirteen in number.

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The Journal of the Michigan State Medical Society made its appearance September first. Owing to the crowded condition of our columns we are obliged to postpone a review of it until our next issue.

\* \* \* \* \*

The matter of American Medical Journals is of such importance that we may take up other phases of the subject in our future issues.

### New Incorporations.

The Secretary of State at Springfield has licensed the following corporations:

Whiteford Chemical company, Chicago; capital, \$25,000; to manufacture and deal in druggists' and physicians' supplies. Incorporators, E. D. McMillan, Whiteford E. J. McMillan, and Walter S. Lawson.

Grove Home for Convalescents, Evanston; philanthropic; incorporators, Edwin F. Marsh, Charles Norwood Henderson, and Augustus S. Peabody.

The Hermit Remedy company, Chicago; capital, \$10,000; manufacturing proprietary medicine; incorporators: Mac C. Allen, Edward J. Brundage, and Frank Little.

### Local Societies.

The Grundy County Medical Society met September —, 1902, in Mazon, Ill., as the guest of O. P. Bennett and held a very enthusiastic meeting. M. L. Harris, president of the State Society and W. S. Christopher of Chicago were the guests of the evening and at the close of

an excellent banquet presented subjects pertaining to their special lines of work.

The meeting broke up at a late hour and all agreed that this was one of the most successful and profitable in the history of the Society.

H. M. Ferguson,  
Official Reporter.

The Morgan County Medical Society met in regular session on Thursday, August 14, 1902, at its rooms in the Hockenhull building.

In the absence of both the president and vice-president Frank P. Norbury acted as chairman.

Members present—Drs. Cole, Norbury, Pitner and Wakely.

The minutes of the July meeting were approved as printed.

The president announced the program for September 11, 1902:

**Cancer and its Treatment**—J. A. Day and J. W. Hairgrove. Leaders—George Edwin Baxter, Bowe and Milligan.

R. H. Garm, of Beardstown, was elected to membership.

A communication from E. W. Weis, secretary of the Illinois State Medical Society, was received asking that "a blank application to become a branch of the Illinois State Medical Society enclosed be filled out and returned" to the secretary of the Illinois State Medical Society. The secretary of this Society reports that such action was taken, said application being signed by the president and secretary of this Society.

Letters were also received from George Edwin Baxter, now of Chicago, Ill., and W. W. Crane, of Sinclair, Ill.

W. C. Cole read a paper on **Malarial Fever**.

The discussion was participated in by all present.

On motion of the secretary, seconded by Dr. Pitner, the following resolution was adopted:

Resolved, That the adoption of the form of constitution and by-laws for County Societies reported by a committee of the American Medical Association and printed in full in the Journal of the American Medical Association for August 9, 1902, subject to amendment be considered at the next regular meeting of this Society on September 11, 1902.

The motion prevailed.

On motion the Society adjourned.

T. A. Wakely, Official Reporter.

The Decatur Medical Society met Aug. 29, 1902, S. J. Bumstead presiding. Dr. Bumstead invited the Society to hold its September meeting at his residence, an invitation that was unanimously accepted.

M. V. Lonergan read a paper on "Intestinal Diseases of Children in Summer Time." This was followed by general discussion.

W. C. Wood talked of different things in the news line in current medical literature.

At the next meeting F. M. Anderson will

have a paper on "**Cerebral Localization**," and the discussion will be led by E. A. Morgan and Lynn M. Barnes.

**The Physicians' Club of Chicago** held its opening meeting at De Jonghe's, Monday, September 29, 1902.

Chairman: Frank Billings.

Program—Subject: "**The Present Epidemic of Typhoid Fever in Chicago**."

Speakers:

Edwin O. Jordan, Associate Professor of Bacteriology, University of Chicago.

John H. Long, Professor of Chemistry, Northwestern University Medical School.

Mr. E. G. Cooley, Superintendent of Schools, Chicago.

Adolph Gehrmann, Formerly Director of Bacteriological Laboratory, Board of Health, Chicago.

The club has issued a tastily prepared pamphlet giving the constitution and by-laws, program of each meeting since the club was founded and a list of members and officers.

The following gentlemen have applied for membership in the club: Ludwig S. Simon, 4254 Vincennes avenue; E. A. Fischkin, 4809 Prairie avenue; Alfred C. Croftan, 6026 Monroe avenue.

A report of the meetings of the club will appear in the Journal of the Illinois State Medical Society. This meeting will be reported in full in the next Journal.

L. Harrison Mettler,  
Official Reporter.

**The Chicago Gynecological Society** held its regular meeting Sept. 19, 1902, Vice-President J. Hoag in the chair.

Dr. Dodds presented specimens of **fibroid tumor of the ovary**.

J. B. DeLee exhibited **Bossi's Uterine Dilator for use in dilating the cervix in labor**. The value of the instrument was questioned by Drs. Kolischer, Webster and Hoag.

Herbert Stowe reported a case of **rupture of the umbilical vein after injury** to the mother by the kick of a horse. The cord was wound twice around the neck of the fetus. Dr. Stowe explained the rupture of the vessel by supposing that the cord lay over the back of the child which was in contact with the abdomen of the mother. The horse's foot came over this region and produced the tear in the probably diseased blood vessel. The fetus was syphilitic.

Dr. Stowe also reported another case of **rupture of the cord due to the precipitate birth** of the child which fell on the floor. In connection with these cases he discussed the subject of the strength of the cord and reported observations made by himself. The paper was discussed by Drs. DeLee, Bacon and Webster. Dr. DeLee reported an additional case. Dr. Bacon doubted the explanation of the rupture of the vein in the first case and held that spontaneous rupture of syphilitic vessels was more probable. Dr. Webster called attention to the different kinds and seats of rupture of the cord and held that the usual investigations concerning its strength were of no practical value.

E. M. Sutton of Peoria reported a case of **cancer of the vagina** and described his operation for its removal. The case was complicated with a stricture of the rectum extending up about 8 inches from the anus, which necessitated the removal of the rectum. The operation began with the removal of the sacrum below the second sacral vertebra. The vagina, cervix and rectum were then removed and the end of the rectum fastened to the skin. The patient made a good recovery. Dr. Evans reported the pathological findings and discussed the relation of the fibrous stricture to the epithelial cancer of the vagina. Drs. Kolischer and Ries criticised the operation holding that the sacral route was not necessary.

Dr. Kolischer read a paper on the **condition of the bladder after hysterectomy**.

C. S. Bacon, Official Reporter.

**The Tri-County Medical Society**—(Vermilion, Iroquois and Ford Counties,) held its annual summer meeting in Watseka, June 3d. There was an average attendance and a fine spirit throughout both the sessions. A. M. Wylie of Paxton, president of the Society being in Europe, the chairmanship fell to Vice-President Frank M. Mason, of Rossville.

The morning session opened at 10:30 and was wholly devoted to the routine business of the Society, hearing reports of officers, committees, etc., the election of new members, and the election of officers for the coming year.

Dr. Mason gave a fine opening address—J. A. Miller of Loda, Robert E. McKenzie of Gilmar and J. S. Near of Watseka, were all made members.

The books of the secretary-treasurer were destroyed by fire last December, but he reported briefly from memory.

Officers chosen for the coming year were: President, Frank M. Mason of Rossville; Vice-President, Carey Culbertson of Piper City; Secretary-Treasurer, L. Jones of Hoopeston; Board of Censors, Mary B. Newell of Onarga, T. N. Bone of Loda and D. W. Miller of Gilmar.

Hoopeston asked for the winter meeting next December and it was granted.

The meeting then adjourned for dinner—the Watseka Doctors had prepared a genuine spread at the Williams House—and it was fully appreciated by the visiting Doctors.

The afternoon session began at 2:30 and was devoted to the reading and discussion of papers, reports of cases, etc.

Mrs. Mary B. Newell of Onarga read a fine paper on **The Ills and Treatment Peculiar to Children**.

Leroy Jones of Hoopeston gave a paper on **Auto-intoxication**. Carey Culbertson of Piper City read a paper on **The Surgical Teachings of Obstetrics**. E. E. Clark of Danville read his Quincy (Illinois State Medical Society) paper on **Dacryocystitis**. B. L. Evans of Watseka gave a verbal report of the Quincy meeting. Cases of violent bleeding were reported by Ethan Allen of Sheldon, and O. O. Hall of Milford. The discussions were able and instructive. Having disposed of the purely business and routine work of the Society in the morning session, left the afternoon all for the papers,



reported cases, and discussions. The plan was new to our Society, but we will use it again.

The Society has never had a better meeting than this one, but we expect a good one next December at Hoopston.

LeRoy Jones, Official Reporter.

The Adams County Medical Society held a very pleasant meeting at Camp Point on Sept. 8, 1902. There were about 35 in attendance. It was both a scientific and social meeting, much enjoyed by all present. An address of welcome was given by S. Henry of Camp Point. W. Gilliland, president of the Society, read a paper of much interest to the profession entitled **Every Member's Obligation**.

J. M. Grimes responded with a few remarks on the uselessness of attempting to prosecute the traveling medical vender as he has probably engaged in other fields when case comes to trial.

R. Christie, Jr., and J. Robbins, also made a few appropriate remarks. H. Hatch spoke of the laudable position held by the physician of today and gave due credit to lately deceased Rudolph Virchow.

A recess was then taken during which time the gentlemen indulged in various athletic sports.

After a delightful supper and the thanks of the Society extended to the ladies of Camp Point for their hospitality the members departed for their various destinations.

Sarah Vasen, Secretary pro tem.

The Sangamon County Medical Society met in regular session, Monday evening, September 8th, at eight o'clock in the court house, L. C. Taylor president, in the chair. The minutes of the May meeting having been mislaid were not read. The minutes of the special meeting in regard to Dr. Fisher's death were read and approved. Bills of A. C. Brown, Phillips Bros., Edw. Hartman Co., and secretary were read and ordered paid. The following resolution was read by G. N. Kreider:

Whereas, the distinguished scientist Prof. Rudolph Virchow was called from the scene of his earthly labors on Saturday the 6th of September, 1902. We the members of the Sangamon County Medical Society of the State of Illinois in regular meeting assembled, take this occasion to put on record our appreciation of this great man whose genius has marked an epoch in the science of medicine, whose devotion to truth and freedom have been of infinite benefit to his countrymen and whose moral character during a long and busy life has been above reproach.

Resolved, that a copy of this minute be published in the Illinois Medical Journal, the Journal of the American Medical Association and a copy be sent to his son, Prof. Hans Virchow.

Motion was made and carried to change our by-laws to conform with that of State Society in regard to admitting other than graduates of regular schools as members of our Society. The application of W. B. Pickrell for

membership, with letter was read and referred to the executive committee.

The announcement of Prof. William Osler's address on "William Beaumont, the First and Greatest American Physiologist," under the auspices of the St. Louis Medical Society of Missouri was read.

Walter Ryan gave a short talk on two cases of stab wounds where arteries were sutured, a synopsis of which follows: Case No. 1. A young colored man stabbed just below the clavicle with pocket knife, he placed his finger in the wound and kept it there until they reached the hospital; after cutting down under the clavicle the subclavian artery was found to be punctured, the Lembert suture was used and complete recovery followed. Case No. 2. An Italian stabbed by a colored man, the axillary artery being punctured, a pocket handkerchief being placed in the axilla with the arm held firmly against the body to control hemorrhage till they reached the hospital where Lembert sutures were used with complete recovery.

Dr. Ryan also presented several specimens of gall stones, stating that all cases of gall stones did not have jaundice accompanying them. G. N. Kreider reported a case in which a boy was shot in the chest with a 22 calibre rifle, the ball ranging upward. According to latest authority such wounds should be left alone. In this case, the chest was tied down with adhesive strips to cause abdominal breathing, thereby lessening the liability of blood collecting in the pleural cavity and causing pressure on the vital organs. Dr. Kreider also reported a case which he had recently seen in Roosevelt Hospital, New York City, in which Prof. Weir had found a **function for the appendix vermiformis**. The patient suffered with a chronic colitis for which it was proposed to make an opening in the bowel for the introduction of remedies directly to the diseased part. On opening the abdomen in the cecal region the healthy appendix popped into view and Prof. Weir took the hint of using this as a channel instead of sewing the cecum to the abdominal wall as he had intended. He accordingly brought it into the wound clipped off the end and afterwards injected remedies into the colon through it. The man made a good recovery. There being no further business the Society adjourned.

Percy Louis Taylor,  
Official Reporter.

#### Stark County Medical Society.

Meets semi-annually in Wyoming, Second Tuesday of April and October.

#### Officers.

President, A. M. Pierce.....Wyoming  
Vice-President, L. S. Hopkins.....Bradford  
Secretary and Treasurer, M. T. Ward....Toulon

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Holgate, Jas., Wyoming.  
Hopkins, L. S., Bradford.



Johnson, A. L., Castleton.  
 Parsons, Arthur, Elmira.  
 Pierce, A. M., Wyoming.  
 \*Ward, M. T., Toulon.  
 Wead, J. S., Wyoming.

#### Ogle County Medical Society.

Meets First Wednesday in January and July.

##### Officers.

President, G. M. McKenney.....Oregon  
 Vice-President, W. W. Barnes.....Polo  
 Secretary, H. A. Mix.....Oregon  
 Treasurer, L. S. Hall.....Oregon

##### Members.

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 Balsbough, G. S., Forresteron.  
 Barnes, W. W., Polo.  
 Carlton, W., Rochelle.  
 Covell, Jno. D., Forresteron.  
 Cummings, A. F., Rockford.  
 Hall, L. S., Oregon.  
 Harvey, T., Stillman Valley.  
 \*Kretsinger, Josiah T., Leaf River.  
 Mendenhall, A. L., Kings.  
 Mix, H. A., Oregon.  
 McCosh, Geo. B., Mt. Morris.  
 McKenney, G. M., Oregon.  
 Normell, L. C., Oregon.  
 Pankhurst, Jas., Grand Detour.  
 Snyder, J. B., Polo.  
 Speaker, W. T., Mt. Morris.  
 Vanvoorhis, J. F., Creston.  
 Woodcock, Albert J., Byron.

#### Grundy County Medical Society.

##### Officers.

President, O. P. Bennett.....Mazon  
 Vice-President, Jno. E. Brock.....Coal City  
 Secretary, Harry M. Ferguson.....Morris  
 Treasurer, Wm. E. Walsh.....Morris

##### Members.

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 †\*Brock, Jno. E., Coal City.  
 \*Ferguson, Harry M., Morris.  
 Hanawalt, C. G., Lisbon.  
 Nelson, Gerhard T., Morris.  
 Palmer, A. E., Morris.  
 Palmer, F. A., Gardner.  
 Pickles, Wm. H., Coal City.  
 \*Walsh, Wm. E., Morris.

#### Bond County Medical Society.

##### Officers.

President, El. P. Poindexter.....Greenville  
 Vice-President, J. A. Warren.....Greenville  
 Secretary, W. T. Easley.....Greenville  
 Treasurer, W. G. Barnes.....Mulberry Grove

##### Members.

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 Cary, A. B., Donnellson.  
 Cary, J. B., Donnellson.  
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 Coop, Bedford F., Greenville.  
 Duncan, W. W., Sorento.  
 Early, H. C., Reno.  
 †\*Easley, Wm. T., Greenville.  
 †Glasgow, E. A., Mulberry Grove.  
 Gordon, C. C., Greenville.  
 Gordon, Ed., Old Ripley.

\*Gordon, J. H., Pocahontas.  
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 Poindexter, E. P., Greenville.  
 Schmidt, H., Beaver Creek.  
 Vaughn, S. A., Smithboro.  
 Warren, J. A., Greenville.  
 Wilkins, David R., Pocahontas.  
 Wilkins, H. E., Sorento.

#### Tazewell County Medical Society.

##### Officers.

President, W. H. Conibear.....Morton  
 Secretary-Treasurer, C. G. Muehlman....Pekin

##### Censors.

J. M. Cody.....Tremont  
 J. I. Skelly.....Pekin  
 R. H. Keyes.....Hopedale

##### Members.

\*Beilstein, F. W., Morton.  
 \*Cody, J. M., Tremont.  
 \*Conibear, W. H., Morton.  
 \*Keyes, Robt. H., Hopedale.  
 Muehlman, C. G., Pekin.  
 \*Niergarth, Wm., Pekin.  
 †\*Skelly, J. I., Pekin.  
 Weimer, E. H., Pekin.  
 \*Yoder, H. L., Morton.

#### Greene County Medical Society.

Meets second Friday in September, December  
 and June.

##### Officers.

President, F. A. Clement.....Greenfield  
 1st Vice-President, H. W. Hand....White Hall  
 2d Vice-President, J. A. Gravens..Wrightsville  
 Secretary-Treasurer, H. A. Chapin...Whitehall

##### Members.

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 Bowman, A., Whitehall.  
 Burns, Geo. W., Whitehall.  
 Burns, Howard, Carrollton.  
 †\*Chapin, H. A., Whitehall.  
 †\*Chapman, H. W., Whitehall.  
 \*Clement, F. A., Greenfield.  
 Converse, H., Greenfield.  
 Coon, J. T., Carrollton.  
 Cravens, J. A., Wrightsville.  
 Foreman, A. W., Whitehall.  
 Gooch, E. S., Carrollton.  
 Hall, T. H., Carrollton.  
 \*Hand, H. W., Whitehall.  
 Hayes, J. B., Carrollton.  
 \*Higbee, E. H., Roodhouse.  
 Jouett, E. E., Woody.  
 \*Redwine, J. W., Whitehall.  
 †\*Ross, G. W., Carrollton.  
 Squin, Jas., Carrollton.  
 Waters, J. E., Athensville.

#### Randolph County Medical Society.

##### Officers.

President, W. R. McKenzie.....Chester  
 Vice-President, A. T. Telford.....Menard  
 Secretary and Treasurer, H. C. Adderly.Chester

##### Members.

\*Adderly, H. C., Chester.  
 Beattie, J. G., Preston.  
 \*Dinges, H. A., Red Bud.  
 Gillen, P. J., Prairie du Rocher.  
 Gordon, H. A., Chester.  
 Hill, E. L., Percy.

Isom, W. C., Rockwood.  
James, W. A., Chester.  
Meyer, F. J., Evansville.  
McKee, H. T., Sparta.  
\*McKenzie, W. R., Chester.  
Pantler, N. B., Evansville.  
Robertson, J. W., Coulterville.

†Robertson, Thos., Steelsville.

\*Smith, C. G., Red Bud.

Songer, W. E., Menard.

Steele, A. D., Chester.

\*Telford, A. T., Menard.

#### Richland County Medical Society.

Meets last Saturday of each month.

##### Officers.

President, A. L. Ziliak.....Olney

Vice-President, E. Rowland.....Olney

Secretary, M. E. Poland.....Calhoun

Treasurer, J. W. Spain.....Olney

##### Members.

Bower, D. W., Calhoun.

Foster, M. D., Olney.

Fritschle, W. E., Olney.

Martin, C. E., Claremont.

Poland, M. E., Calhoun.

Rowland, E., Olney.

Soliss, J. P., Olney.

Spain, J. W., Olney.

Thompson, W. A., Olney.

Watkins, H. T., Olney.

\*Weber, G. T., Olney.

Ziliak, A. L., Olney.

The Christian County Medical Society was organized at a meeting held in the city hall, Taylorville, Ill., September 2, 1902. The following physicians were present:

J. N. Nelms, Taylorville.

W. K. Wright, Taylorville.

M. M. Hill, Taylorville.

F. E. North, Taylorville.

Dr. Dixon, Taylorville.

T. M. Johns, Taylorville.

F. R. Morton, Taylorville.

J. F. Miller, Palmer.

J. P. Simpson, Palmer.

M. W. Staples, Grove City.

C. W. Coe, Stonington.

W. T. Short, Stonington.

W. T. Bridges, Stonington.

W. J. Saling, Stonington.

It was decided to adopt the constitution and by-laws recommended by the committee of the American Medical Association for the use of county societies modified to meet the wants of this Society.

J. N. Nelms was elected president; W. T. Bridges was elected secretary-treasurer.

W. T. Bridges, Official Reporter.

#### The Aux Plaines Medical Society.

##### List of Members.

W. F. Scott, Melrose Park.

W. R. Livingston, Maywood.

H. W. Merrill, Maywood.

V. N. Swan, Maywood.

Geo. C. Shockey, Melrose Park.

Fred H. Bates, Elmhurst.

Wm. T. Pickard, Maywood.

Rodney Hunt, Oak Park.

Arthur Loewy, Oak Park.

A. W. Rosenberry, Oak Park.

Chas. W. Oleson, Lombard.

O. K. Handke, Harlem, Oak Park P. O.

H. E. Dodge, Franklin Park.

C. E. Hemingway, Oak Park.

J. H. McDonald, 1384 W. Congress, Chicago.

E. F. Knapp, River Forest, Oak Park P. O.

G. B. Tope, Glen Ellyn.

F. J. T. Fischer, Elmhurst.

H. W. Vanderhoof, Wheaton.

C. Shorman, 212 Baird ave., Austin.

Henry F. Langhorst, Elmhurst.

Irving Peak, Oak Park.

Joseph H. Hilton, Maywood.

Ellis Kirk Kerr, 214 N. Elmwood ave., Oak Park.

W. R. Livingston, Official Reporter.

The McLean County Medical Society met after the hot weather vacation of two months, in the city hall, September 4th, at 7:30 P. M. Eliza J. Hyndman read the paper of the evening reporting a case and reviewing the literature on **Tetany**. Her case was a child about one year old who had a mechanical obstruction of the bowels near the sigmoid flexure. The Tetany was relieved as soon as the bowels were thoroughly cleaned out. The disease being an uncommon one, but few of the members present had ever recognized a case. Dr. Sloan of Danvers had seen two cases, one that he considered very serious, after consultation was given one-half grain of codeine every three hours for two days, the child recovering. The Society has issued a neat pamphlet giving the program for each meeting during the year and containing a list of the officers and names of members corrected to date. Members present: J. W. Smith, J. L. Yolton, Kaesar, Hyndman, Bath, Nussbaum, C. M. Noble, Cox, Hull, R. G. Yolton, Sloan, Fox, Chapin and Deedy.

E. S. Reedy, Official Reporter.

##### Officers 1902-1903.

J. Whitefield Smith.....President

Lee Smith.....Vice-President

E. S. Reedy.....Secretary and Treasurer

##### Censors.

E. Mammen, Geo. R. Smith,

J. P. K. Hawks.

##### List of Members.

September 1, 1902.

C. Ayling, Gridley.

A. A. Absher, Sibley.

A. C. Albright, Sibley.

C. H. Beadles, Jacksonville.

J. Y. Bonnett, Bloomington.

T. W. Bath, Bloomington.

L. A. Burr, Bloomington.

Samuel Bane, Ellsworth.

J. H. Banks, Atlanta.

S. L. Chapin, Saybrook.

H. S. Chapin, Holder.

Chas. E. Chapin, Bloomington.

E. G. Covington, Bloomington.

C. R. Carr, Bloomington.

A. L. Chapman, Carlock.

J. E. Covey, Lexington.

J. M. Cody, Tremont.

B. F. Cox, Farmer City.

S. L. Crocker, Weston.

D. T. Douglass, Colfax.  
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 H. W. Elder, Bloomington.  
 G. D. Elder, Bloomington.  
 J. W. Fulwiler, Bloomington.  
 J. A. Fenelon, Bloomington.  
 A. L. Fox, Bloomington.  
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 M. D. Hull, Bloomington.  
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 A. F. Henton, Bloomington.  
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 Eliza J. Hyndman, Bloomington.  
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 W. L. Horn, Arrowsmith.  
 C. E. Heyward, Cropsey.  
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 F. O. Jackman, Bloomington.  
 A. F. Kaeser, Bloomington.  
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 L. S. Keith, Towanda.  
 Homer A. Kell, Danvers.  
 J. E. Kunkler, Bloomington.  
 J. Little, Bloomington.  
 E. Mammen, Bloomington.  
 T. R. Mullen, Bloomington.  
 A. W. Meyer, Bloomington.  
 Nelson McCormick, Normal.  
 F. C. McCormick, Normal.

F. J. Mittan, Colfax.  
 J. P. Noble, McLean.  
 C. M. Noble, Bloomington.  
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 F. J. Parkhurst, Danvers.  
 A. R. Penniman, Stanford.  
 C. R. Parke, Bloomington.  
 Wm. Patch, Whitefield.  
 E. S. Reedy, Bloomington.  
 W. H. Reedy, Towanda.  
 C. B. Roberts, Towanda.  
 A. E. Rogers, Bloomington.  
 Frank Stubblefield, El Paso.  
 J. A. Smith, El Paso.  
 L. E. Speer, Shirley.  
 C. C. Sater, Atlanta.  
 L. A. Skaggs, Ellsworth.  
 W. R. Shinn, Chenoa.  
 Lee Smith, Bloomington.  
 G. R. Smith, Bloomington.  
 J. Whitefield Smith, Bloomington.  
 E. E. Sargent, LeRoy.  
 E. P. Sloan, Danvers.  
 J. A. Tuthill, Danvers.  
 E. K. M. Taylor, Danvers.  
 J. B. Taylor, Bloomington.  
 F. C. Vandervort, Bloomington.  
 W. T. Williamson, Lexington.  
 M. P. Ward, Belleflower.  
 F. J. Welch, Bloomington.  
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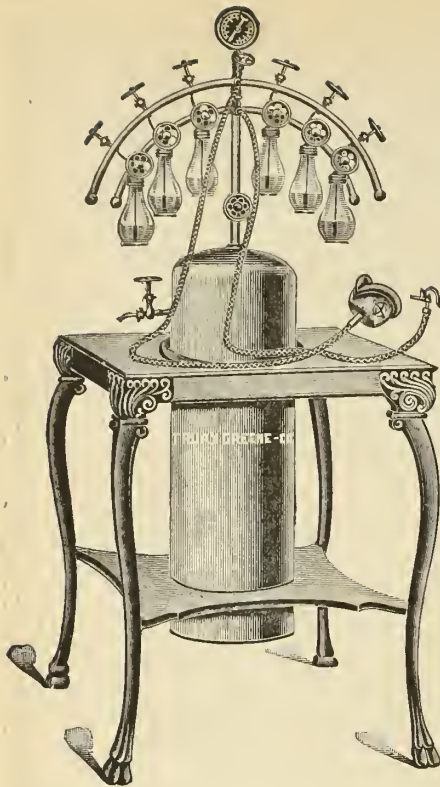


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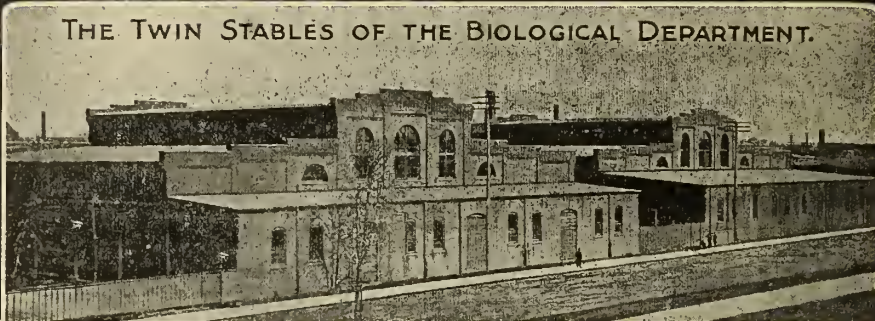
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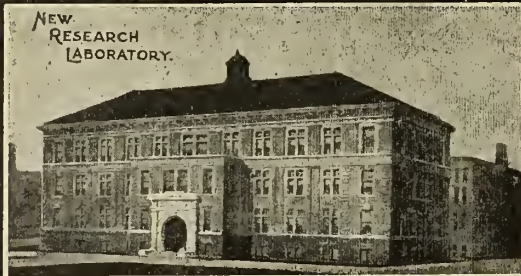
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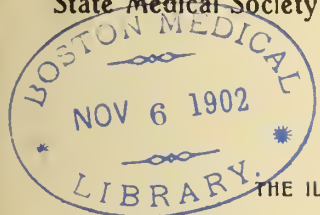
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Entered in the Springfield Postoffice as Second-Class Matter.

Volume LII.  
New Series, Vol. IV.  
Number 6.

Springfield, Ill., November, 1902.

Subscription, \$3 a Year.  
Single Copies, 25 Cents.

## LOCAL SOCIETIES ENDORSE THE NEW LAW.

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# The Illinois Medical Journal.

The Official Organ of The Illinois State Medical Society.

VOL. LII.  
New Series, Vol. IV. }  
No. 6.

Springfield, Ill., November, 1902.

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## SOME POINTS IN THE PREVENTION AND MANAGEMENT OF POST- PARTUM HEMORRHAGE.\*

BY C. S. BACON, M. D., CHICAGO.

The subject of post-partum hemorrhage is always of interest and will probably continue to be one of the most important subjects to engage the attention of accoucheur and nurse as long as the human race exists. Several questions concerning the prevention, causation and the treatment of this condition are in dispute and have been considerably discussed during the last ten years. I wish to give you a few conclusions that some study of the subject has enabled me to make.

The frequency of fatal post-partum hemorrhage has been found to vary considerably in different places. Some have found only about one death in ten thousand cases of labor while others have found nearly one death in one thousand cases. I have tried to reach an approximate conclusion as to the mortality from this cause in the city of Chicago. The data are uncertain, first because, on account of the imperfect report of births, the number of births or labors each year is not exactly known and secondly because some deaths from hemorrhage are returned as due to other causes. From my study of the mortality records I have come to the conclusion that the deaths due to post-partum hemorrhage are about one-tenth of the deaths due to all puerperal affections. This ratio is a little less than that recently found by Schrader for Hamburg who considers that twelve and fifty-six one hundredths of all obstetrical deaths are due to hemorrhage. The number of births in Chicago must be estimated for only a part are reported by attending physicians and midwives. It is pretty safe to assume a birth rate of between thirty and thirty-five per thousand of population. This gives the number of

births each year between fifty-five and sixty thousand. The number of deaths from all puerperal causes is a little less than 300 a year. The death rate is therefore one in two hundred or five per mille. From these data then we see that the deaths from puerperal hemorrhage are one in two thousand cases of labor or five-tenths per mille or in other words there are thirty deaths from post-partum hemorrhage in Chicago every year.

If we should ask for the frequency of severe hemorrhage we should have to admit that it is almost impossible to find statistical data to furnish an answer to the question. It is difficult to compare the statements of hospitals on account of differences in the meaning of the term severe.

In the health department of a city there are not of course any data to use in forming an opinion. If one were to find it worth while to make a guess he might take the ratio of Studer of Basel who states that in 5 per cent of all labors there is severe hemorrhage. This would give in Chicago 3,000 cases a year which is probably not too large a number. I think it safe to assume that of this number of pathological cases at least 10 per cent or 300 would perhaps have died unless some measures for the control of the hemorrhage had been adopted.

This rudely approximative study of the frequency of post-partum hemorrhage in Chicago alone indicates the reason for the perennial interest in the question. If we now enquire into the various *causes* of hemorrhage we find that we have much less positive knowledge on the subject than is generally supposed. Post-partum hemorrhage is generally ascribed to lacerations of the obstetrical canal generally the cervix uteri or to atony of the uterus. The importance of tears in the production of hemorrhage is of course admitted by all. The only dispute here is over the relative frequency of this etiological factor. Veit several years ago in a very valuable paper that has stimulated

\*Read at the 52d Annual Meeting, Quincy, May 21, 1902.



to much study of this subject held that nearly all fatal hemorrhages were due to traumatic lesions of labor. His position was extreme. No doubt there are many fatal hemorrhages not caused by lacerations but I have no doubt that in this country, at least one-half of the serious or fatal hemorrhages result from this cause. Lacerations causing serious hemorrhages always result from operative interference. Hence the more frequently labor is terminated by the forceps or manual extraction the greater will be the number of hemorrhages from this source. When forceps are applied without complete dilatation of the os the prospect of hemorrhage is greatly increased. Severe lacerations are very often caused by manipulation in manual extraction of the breech. The introduction of the hand alongside the body of the child in bringing down the arms very generally causes a considerable tear of the vagina or the cervix or both. The extraction of the after-coming head through an incompletely dilated cervix generally results in its laceration. For this reason post-partum hemorrhages are so common in cases of placenta previa for these cases are generally treated by version and too often by immediate extraction.

We may then conclude that post-partum hemorrhages due to laceration include about one-half of all serious or fatal hemorrhages and are due to operative interference. The number of such hemorrhages is unnecessarily large for many are due to application of forceps before dilatation of the cervix, some to unnecessary manipulation in breech extractions and some to the bad practice of rapid extraction after version in the treatment of placenta previa.

It is when we come to study atonic hemorrhage that we discover how little we know of the real nature of this condition. Our ignorance results in part from our ignorance of the fundamental facts concerning the parts played by the blood vessels and the blood in the causation and checking of hemorrhage and in part from the still unexplained mechanism of the compression and obliteration of the blood vessels by the uterine muscle fibres. When the placenta is partly or completely separated from the placental site

hemorrhages must occur unless the vessels are closed either by compression or by plugging with thrombi. If they are first closed by constriction or compression clots will soon form in them as in the case of ligated vessels. The compression of the placental vessels as of all uterine vessels is produced by a contraction of the uterine muscles just as in the contraction of any muscle the blood is forced out of it. But another factor also comes into play in compression of the vessels namely the re-arrangement of the muscle fibres of the uterus from their parallel position at the end of pregnancy to the complicated arrangement of the unimpregnated uterus. This re-arrangement of the uterine muscle fibres and their involution result in the retraction of the uterus. If the contractions of the uterus are sufficiently prolonged and the retraction progresses normally the vessels are so closed that clots form that permanently plug the vessels if the coagulating properties of the blood are normal.

Still another factor is undoubtedly important namely the contractility of the vessel wall. Our knowledge of the influence of this factor is very deficient.

In the case of post-partum hemorrhage there are then theoretically and no doubt actually several contributing conditions. First. The vessels may not have normal contractility. Second. The blood may be deficient in coagulability and this lack of coagulation may be inherited as in hemophilia or acquired as in malarial and septic hemorrhagic diatheses. In these states either thrombi do not form or they form very slowly, are not firm and are easily displaced. Third. The uterine muscle does not contract at all and hence there is no constriction of the vessels. This may be due to exhaustion of the muscle or perhaps to inactivity of the inherent ganglia of the uterus which preside over its action. This inactivity may result from inhibition. Fourth. The contractions of the uterus may be short, inefficient and unaccompanied by any retraction. This may also be due to muscle exhaustion or to inhibitory action in the ganglia. These short inefficient contractions of the uterus do not close the vessels long enough to allow the formation of per-

manent clots. Any that are formed are washed out upon the relaxation of the uterus. Fifth. Temporary increase of blood pressure, that caused for example by mental excitement, might dislodge thrombi that but for such increase in blood pressure might have been retained.

It will be seen that the subject of post-partum hemorrhage not due to laceration, the so-called "atonic" hemorrhages, better the non-traumatic hemorrhages, is not so simple as one might be led to believe from the textbook treatment of the subject. The influence of the blood conditions in particular is generally entirely ignored yet that it is very important I have no doubt. I have myself seen severe cases of hemorrhage, one fatal, where there was no laceration and where the contraction of the uterus was good. This hemorrhagic diathesis is generally acquired and frequently unsuspected.

The rules for the prevention of hemorrhage due to laceration are implied in what has been said of the causation of these lacerations. The subject of the prevention of post-partum hemorrhage not due to laceration, the non-traumatic hemorrhages needs further elucidation.

Hemorrhagic conditions of the blood are rarely suspected beforehand and therefore prophylactic treatment of this condition is generally impossible. In case of a known hemophilia or an acquired hemorrhagic diathesis an agent to increase the coagulability of the blood is indicated. It is known that calcium is an essential constituent of fibrin and its administration will increase the formation of fibrin. Hence it should be given during the last weeks of pregnancy in these states. When there is a history of previous post-partum hemorrhage the possibilities that they were due to a hemorrhagic condition of the blood should be kept in mind. The calcium treatment may be instituted for even if there is no lack of it in the blood it will do no harm even if it increase the blood coagulation beyond the normal. It would be desirable to examine the blood for its degree of coagulation, in all suspicious cases. The method of Vierordt and of Wright in the use of capillary tubes both give results of value and are quite easily employed.

Since mental excitement or violent exertion may cause a sudden increase in blood pressure that may wash out forming thrombi such factors should be eliminated by keeping the patient quiet, by calming her fears by a confident reassuring manner.

As mentioned before vascular dilatation or lack of the normal vascular contractibility may be of importance in some cases of hemorrhage. As a vascular sedative acting on the arterioles certain drugs like ergot and digitalis would be indicated during labor. Their action on the uterine muscles is so important however that this must be chiefly considered.

The causes of muscular atony of the uterus may be grouped under three heads. The muscle may be weak, it may be exhausted and there may be imperfect retraction of the uterus or re-arrangement of its component fibres. The relative weakness of the uterine muscle may be congenital or it may result from a debilitated condition of the system, or it may be due to some injury as a partial rupture in a previous confinement or finally it may result from a metritis. The exhaustion is the result of a long and severe labor whether such a prolonged labor may have been caused by difficulty in the dilatation of the cervix or of the vulvar outlet or by a contracted pelvis or by a relatively large child. The progressive and satisfactory retraction of the uterus is interfered with in cases of its over distension for instance in hydramnion and in multiple pregnancy and also in cases of too rapid labor. This is the condition in rapid operative deliveries.

It will be seen there are grouped together under the head of muscular atony quite different etiological factors and the best management of the cases compels a study of the different conditions. Assistance in delivery may be required in cases of weak or exhausted muscles, while in cases of over distension of the uterus we might seek to prolong labor.

In all these conditions however the course of the third stage of labor is of very great importance. A long rest of the uterus before the expulsion of the placenta is desirable. Such a rest not only allows the weakened and exhausted muscle to recuperate but also permits re-arrangement of the

muscle fibres. The common practice of expressing or extracting the placenta immediately or soon after the birth of the child is undoubtedly responsible for much atonic hemorrhage. This practice is so common that many are quite ignorant of nature's method of removing the placenta. A delay of 15 or twenty minutes excites the fear that there is adhesion of the placenta that requires interference. If the physician would quietly sit by his patient and study the method of nature he would find one to four hours is a perfectly normal duration for the third stage. During this time retraction or involution has been quietly progressing with recuperation of the tired muscle and a gradual closing of the placental vessels so that finally the after birth is expelled normally with no loss of blood.

There should be no stimulation of the uterus by external massage even of the lightest. If the hand be placed on the abdomen it should rest quietly and simply tell us the action of the uterus and indicate any possible tendency to internal hemorrhage. To carry out this conservative waiting policy in the management of the third stage the cord should be cut off close to the vulva, a small aseptic napkin applied and all discharges and wet pads removed from under the patient.

How long should one wait? If the placenta remains in the uterus and no hemorrhage of consequence indicates interference I should not think of interfering in less than two hours and if not compelled by considerations of policy should prefer to wait three or longer.

When the placenta is expelled from the body of the uterus into the cervix and vagina there is perhaps no very good reason for longer delay. Yet in the absence of hemorrhage I see no reason for haste and prefer even here to wait 15 or 20 minutes longer in hope of a spontaneous expulsion of the after birth from the vagina.

Of course in case of serious hemorrhage during this stage the placenta must be expelled and the treatment of hemorrhage begun. Here the only observation I would make is the caution not to mistake an early gush of blood for dangerous hemorrhage.

It often happens that after such a gush of blood that follows the expulsion of the child the uterus contracts down on the placenta, no more bleeding occurs while the third stage progresses in the normal way for one or two hours.

As long as there is no separation of the placenta there is no danger but rather great good from a long third stage. It should be welcomed in all cases of suspected "muscular atony." If there is partial separation of the placenta there may be some hemorrhage at first that ceases and then the third stage progresses naturally.

There is considerable difference of opinion concerning the use of ergot as a prophylactic. On account of its well known effect in stimulating uterine contractions and probably because of its effect on the arterioles as before mentioned, it is given by some during labor in suspected cases and by Athill its use during the last weeks of pregnancy is strongly recommended. Probably the fear of its deleterious effect upon the child when given in proper doses has been exaggerated and a careful study of it may show its use to be of value. The same may be said of digitalis and other vascular sedatives.

The lack of innervation of the uterine muscle has been alluded to as a possible cause of inefficient uterine contraction. The chief interest in this question concerns the effect of anesthetics and sedative drugs. During labor chloroform and ether interfere with the uterine contractions and the same may be true after the expulsion of the child. These considerations would make us careful of their use in suspected cases. It seems quite well proven that the effect of ether is less than chloroform and passes away quickly after the stoppage of the anesthetic. Therefore ether should be preferred to chloroform and it may indeed substitute chloroform in all obstetric practice.

The best prevention of serious post-partum hemorrhage is the prompt treatment and control of a hemorrhage at its beginning. Careful observation of a case will generally enable one to detect a pathological hemorrhage before it has become serious and the institution of immediate therapeutic meas-



ures will prevent it from becoming serious. Even in the most urgent and alarming case previous preparation which enables one to begin treatment without 15 seconds delay will avoid the most serious and fatal development.

The treatment of traumatic hemorrhage is the prompt repair of the lacerations. If an immediate and continuous hemorrhage follows an operative delivery we should at once suspect a traumatic hemorrhage and at once arrange for surgical hemostasis. There ought to be no delay in beginning the repair of the lacerations for the probability of tears and hemorrhage should have been assumed before beginning the obstetrical operation and the necessary instruments got in readiness for possible use. These instruments are large, broad vaginal retractors, bullet forceps, dressing forceps, needle holder, needles, suture material, catgut that will last one week, and scissors. The patient should be at once put on a table in a good light. A sheet to hold the legs enables us to get on with little assistance. Anesthesia is of course desirable but not absolutely necessary in urgent cases. Both lips of the cervix are grasped by the traction forceps and the uterus pulled down to the outlet. Then the suture is applied as high up as possible on the side of the tear in the cervix and tied. If this suture is not high enough to control the hemorrhage from the angle of the wound traction is made with the suture and another one applied above it. In case the hemorrhage is from a tear in the vagina that is of course repaired in the usual way.

There are four ways in which we may seek to control nontraumatic hemorrhage. First. We may try to aid nature to check the hemorrhage in the usual way by stimulating the atonic uterine muscle to efficient contractions. This may be done by massage through the abdominal wall, by massage through the vagina, and by combined massage. We may also stimulate the uterus by hot injections into the vagina and into the uterus. We may also introduce the hand or any other substance into the uterus. Gauze packing of the uterus is efficient chiefly through its effect in stimulating

uterine contractions. The contractions of the uterus is also induced by giving ergot.

Second. We may apply styptics directly to the interior of the uterus.

Third. We may mechanically stop the hemorrhage by packing. Ordinarily the gauze packing acts chiefly through its influence in stimulating the uterine contractions. Were there no contractions of the uterus it would require more than one 25-yard package of gauze to fill it and mechanically compress the bleeding vessels.

Fourth. We may compress the bleeding uterine vessels or the aorta.

The last method is of course only of temporary use in the great emergencies until other measures can be adopted. Styptics, formerly much used have been abandoned by most authorities. I believe however, they still have a place when properly directed efforts at uterine stimulation are either inefficient in causing the uterus to contract or when bleeding continues in spite of good contraction on account of a hemorrhagic diathesis. The persulphate of iron or other powerful styptic would in those extremely rare cases furnish quite as good chances for success as hysterectomy or inversion of the uterus with ligation which have been recommended by some. These cases are very rare but yet occur and require us to be provided with a styptic for the greatest emergencies.

In this connection I may allude to the possible great value of the local application of suprarenal extract. While I have not used it in post-partum hemorrhages I have had such satisfactory results from its employment in surgical cases that I intend to try it in the next desperate case that appears.

Finally we come to consider the means for stimulating uterine contractions. Ergot is of great value if given in proper doses. For emergencies such as we are considering it should be given hypodermically. For this purpose I use Sharpe and Dohm's ergotole in doses of 30 minims repeated 3 or 4 times at intervals of 10 to 20 minutes. Sometimes a little irritation follows the injection but I have never seen an abscess. Parke-Davis & Co's. aseptic ergot is also efficient and an ideal preparation for hypo-

dermic use but rather more expensive. Generally ergot is given in too small doses or given by the stomach where the absorption is often doubtful.

All must admit that massage of the uterus through the abdomen is a good stimulant and in milder cases efficient. It is to be employed constantly.

For further uterine stimulation I rely entirely upon vaginal or intra-uterine injections of very hot water. 120 degrees. The irrigation should begin the instant the hemorrhage becomes pathologic and should be continued long after all hemorrhage has ceased, an hour or more if necessary. This rule implies that the irrigator and the water are in readiness and that an unlimited supply of hot water is provided.

The rubber sheet protecting the bed makes a good drainage trough by turning in the edges and letting the lower end empty into a pail. The patient is pulled to the edge of the bed, not across it, with her hips partly over the edge and supported by the physician who sits at her side. He, with his left hand, massages the abdomen and with the right introduces the irrigating tube into the vagina or if necessary into the uterus. The assistant has to keep up the supply of hot water and fill the bag and bring the hypodermic syringe and the ergot. A thermometer previously sterilized, for example the bath thermometer, is used to indicate the temperature of the water.

The success of this treatment depends upon the promptness with which it is begun and upon the thoroughness with which it is carried out. The worst thing that one can do is to change about from one treatment to another. Thorough preparation for the treatment here recommended, confident precision in carrying it out will I am sure control any hemorrhage that can be controlled by any measure less dangerous than the use of styptics.

During the last 8 or 10 years much has been said about packing the uterus with gauze for post-partum hemorrhage and now the method has come into very frequent use. I believe it is not more efficient than the method I have just recommended and much more dangerous. This belief is founded

on some experience in both methods. That it is inefficient is proven by the fact that I have seen three fatal cases which were packed and packed well. In all of these cases the packing was saturated, removed, and fresh packing reapplied. This was done by experienced men. In still another case packing was applied three times but in vain and the uterus was removed. Duhasen himself the great advocate of the method has also had a case where he was obliged to remove the uterus on account of failure of packing. The advocates of packing will say that they have seen many cases where the patient would have died unless gauze had been used. These statements of course are not more convincing than would be a statement from an advocate of the douche that a patient would have died unless the douche had been given. I am inclined to believe that the douche is more efficient than the packing for the packing, which acts mainly as a uterine stimulant, may be expelled from the body of the uterus and then perhaps ceases to act while a continuous stream of hot water has a continuous action not only on the uterus but on the blood vessels.

But even if the packing is as efficient as the douche it is much more dangerous. It is the insertion into the uterus, the most susceptible place in the body to an infection, of a substance that may not be quite sterile and that is very easily contaminated during the introduction. The technique of the packing is not very simple, the cervix is often torn by the forceps which hold it making ragged wounds that easily may become infected. The need of competent assistance is much greater than for giving a douche while the shock to the patient is severe.

For these reasons I have become doubtful if the method of packing which is becoming more and more general on account of its recommendation by most text books and teachers has not done harm to obstetrics. I do not mean to say that its use has not saved many cases of serious hemorrhage, but that its general introduction in place of the equally efficient and less dangerous douche is to be regretted.

## THE NEUROLOGIC DIAGNOSIS OF TRAUMATIC LESIONS OF THE SPINAL CORD.\*

BY FRANK PARSONS NORBURY, M. D., JACKSONVILLE, ILLINOIS.

The preliminary difficulty frequently in the way of a neurologic diagnosis in traumatic lesions of the spinal cord, is the want of consideration of the atomic elements of the cord and their functions. The recent conception of the neurone has greatly simplified our anatomic knowledge and the physiologic interpretation of cord phenomena. When Waldeyer, in 1891, proclaimed the doctrine of the neurones he opened the way for, and crossed the threshold of, exact knowledge of minute anatomy of the cord which with assistance of the refinement of histologic technique has developed wonderfully the understanding of its structure. With the accumulation of this all important knowledge, to be used as the fundamental basis for clinical work, there has been a corresponding increase of our knowledge of the disease of the cord.

For the purpose of simplifying the presentation of diagnosis it will be necessary for me to briefly state the essentials of the anatomy of the cord and such clinico-pathologic facts as may contribute to the formulation of a working plan for diagnostic study. Let us try to imagine the cord as made up of segments, thirty-one in number, super-imposed one upon the other continuous in function one with the other, with no line of demarcation between the segments and all united in making up the important nervous pathways of the cord. These pathways having for their function the transmission of definite physiologic impulses from the cortex of the brain to the end organ in the periphery and vice versa. These pathways are not continuous, however, but are made up of communicating neurone complexes, each individual neurone complex, retaining its physiologic and anatomic independence. Thus there are pathways which consist of two, three or even

more successive neurone complexes. (Jakob.) These important pathways are primarily divided into the motor and sensory paths.

The motor pathway or tract has two neurone complexes, viz.: the central or higher level neurones, from the cells in the cortex to the anterior horns, or to the nuclei of the motor cranial nerves and the peripheral or lower level neurones, which are the terminal fibrils extending from the anterior horn of the spinal cord or cranial nuclei to the individual muscle fibres. This is the direct motor pathway, while the indirect motor pathway concerned in co-ordination of muscular movements and the higher reflex and automatic movements are much the same in the arrangements of the neurone complexes.

The sensory pathway is made up of at least three and probably more neurone complexes. The direct peripheral neurone which transmits impulses from the sensory end organs to the cells of spinal ganglia, thence by the posterior roots to the spinal marrow. There, the central or higher level neurone complex is met, which in its complex route, finally reaches the cortex of the brain. The indirect neurone complex by a different route finds its terminus in the cortex. The direct sensory pathway transmits tactile, pain and temperature impressions, while the indirect sensory pathway transmits the co-ordinative sensations from the muscles, joints and viscera. The motor and sensory pathways communicate with each other at two places in their course; first, in the cortex of the brain, in the reaction of consciousness; and second, in the reflex tracts which are not under the domination of the will.

These several pathways or neurones group themselves in columns in the spinal cord, viz.: the anterior, posterior and lateral columns. Along their route at certain levels (called segments) nerve bundles are given off—these processes or bundles, emerge from the cord as nerve roots. There are two roots to each nerve, each having a separate exit from the cord, the motor root coming from the anterior columns and the sensory root from the posterior columns—they unite outside of the cord to form the

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.



spinal nerve. Each segment of the cord gives off a pair of nerves. There are thirty-one pairs of spinal nerves, corresponding to the segments of the cord, viz.: eight cervical, twelve dorsal, five lumbar, five sacral and one or rarely two, coccygeal. Each segment is named after the pair of nerves which arise from it and not from the vertebra at the level of which it lies. (Butler.)

By reason of the varied anastomoses of the spinal nerves with each other the nerve may contain fibres, motor or sensory, from several different segments as is the case in most of the spinal nerves. This is an important fact to remember in spinal localization. Each segment is regarded as a unit possessing certain motor, sensory trophic vaso-motor and reflex functions with reference to the peripheral distribution of the nerve roots which pass from it and enter it. The study of the relationship of the spinal segments bearing the names of regional levels, to the vertebra, is important because it is self-evident that all of the spinal segments are not opposite the vertebra, corresponding in name—again, the infra spinal course of the nerves after they emerge from the cord is longer, the lower we descend the cord. This is noted especially in the cauda-equina made up of nerves from the lumbar and sacral segments which have a long infraspinal course before they emerge. Excellent diagrams have been made by progressive authors showing the relation of the segments of the spinal cord and of the roots and exits of the spinal nerves, to the spinous processes of the vertebrae. Again, it is important to study the localization of the functions of the segments of the spinal cord in order to be able to localize the lesions taking of course into consideration all contributing symptoms which serve to make up a diagnosis. A mass of clinico-physiologic and pathologic facts have been compiled into a most elaborate table by Dana, which based upon the observation of Starr, Dana, Mills, Thorburn and others, may be regarded as the authoratative guide of today.

In order to consider the differential diagnosis of cord lesions, it is necessary to apply

these anatomic physiologic and pathologic facts. This is best done by considering the general symptoms of injuries to the spinal cord.

#### PHYSICAL DIAGNOSIS.

It is of the first importance to get a full history of every case before attempting to consider the special diagnosis of lesions of the spinal cord. History will oftentimes proclaim the nature of the injury and relieve, in a great measure, that seeming mystery which too often enshrouds spinal cord lesions. First, it will give a clew whether or not the spinal column is injured. This complication, with all of its attending possibilities, is a factor which may demand more extensive exploratory inquiry. Secondly, history will enable us to estimate the possibility of the nature of the lesion. Thirdly, history can contribute to the differentiation when the surgeon and neurologist are not wholly in accord, as in injuries from falls from heights or the concussion noticed in railroad and elevator accidents. This difference between surgical and neurologic diagnosis occurs from the absence of external evidences of vertebral injury, and the very prominent presence of symptoms indicating extensive injury to the cord. These cases are, more or less, obscure and diagnosis is difficult; in fact, recovery may take place and the real lesion may never be known. In the event of death the examination of the cord will doubtless clear up the diagnosis, but even then it may require microscopic study to throw light upon the symptoms, especially when the heart respiration and vaso-motor symptoms are prominent. The next step of importance in neurologic diagnosis is inspection—this will lead to the probable location of the site of the lesion where the spinal column is injured and thus lead to the localization as to the level of the lesion in the cord. Inspection, however, is necessarily limited in its scope as we must depend on the more thorough and exhaustive inquiry by special means and methods as to the site and extent of the cord injury.

#### SYMPTOMS.

There are three primary divisions of symptoms, viz.:

1. Motor.
2. Sensory.
3. Reflexes.

The motor symptoms of traumatic diseases of the spinal cord are shown in complete or partial motor paralysis,—or a greater intensity of motor activity as in spastic states, rigidity, contractures, spasms, etc. In fact, every degree of exalted action, from slight variation from normal health, to the most extreme demonstrations of muscular activity; in advanced cases, trepidations and cloni in various situations.

The sensory symptoms are evidenced by changes in the tactile sense, temperature sense, pain sense, muscular sense, articular and tendinous senses.

#### MOTOR SYMPTOMS—PARALYSIS.

Location determined by type of paralysis.

Upper motor neurones, (the cortico spinal complex) if involved produce spastic paralysis of all extremities; the paralysis is incomplete but equally distributed to all of the muscles. No wasting from disease but from disuse. Electric re-actions are negative, the muscles are in high state of irritability, slight touch causes great contractions—associated are increased reflexes deep and superficial and ankle clonus.

When lower motor neurones are involved, paralysis is due to disease of the cells of the peripheral motor neurones in the anterior horn of the cord characterized as follows,—only certain muscles being involved—muscles flabby—relaxed—atrophied—R. D. present—loss of deep reflexes—no spasticity but may have contractures.

#### SENSORY SYMPTOMS.

In the study of sensory symptoms great care must be used for as Mills well says: "The study of cutaneous sensations requires time, patience and method, and unless done carefully the results are worthless, particularly for tactile sensibility. An analytical study necessitates the use of all methods that will determine cutaneous sensibility. The personal equation is to be considered for abilities of discrimination vary with individuals.

The sensory symptoms as before stated are changes in the tactile sense, temperature

sense, pain sense, muscle sense, articular and tendinous senses. Gordinier says: 1. The tactile and muscular sense impressions are conveyed via the posterior nerve roots in the posterior columns; the muscular sense impressions pass up the same side, while the tactile cross over and upward on the opposite side; hence a lesion of the posterior columns will produce anaesthesia and ataxia of one or both sides. 2. The sensory tracts of the cord which transmit sensations of pain and temperature are Gowers antero-lateral ascending tract of the side opposite to the point of entrance, the sensations being carried by collaterals from axones of the cells of the posterior spinal ganglia (post nerve roots) to cells existing in the central gray matter of the same side, the impulses being farther conveyed by the axones of these latter cells through the anterior commission to Gowers tract of the opposite side. "A lesion then, of the central gray matter usually causes a loss of these senses, producing analgesia and thermo-anaesthesia on one or both sides." Owing to the fact that all forms of sensation are conveyed to the cord by means of the posterior nerve roots, a lesion of these roots at their junction with the cord, or in the columns of Burdach will occasion at first irritative symptoms, paresthesia, neuralgic pains, ataxia and later, anaesthesia, analgesia and thermo-anaesthesia.

#### SENSORY LOCALIZATION.

It must be remembered that the peripheral sensory nerves anastomose so freely that to get a total anaesthesia of any part of the skin, the sensory fibres from two adjacent segments of the cord must be destroyed. Walton (*Journal N. & M. Diseases*, Vol. 29, No. 1, p. 6.) thus summarizes the distribution. The upper roots of the brachial plexus supply the cap of the shoulder and the radial side of the arm and hand, while the lower roots supply a strip down the ulnar side of the arm and hand. The seventh dorsal segment supplies the ensiform region, the eleventh dorsal the umbilicus and the lumbar the front and outer and inner aspect of the thigh to the knee and the inner aspect of the leg. The sacral supplies the region below

the knee in front on the outer aspect as well as the whole or greater part of the foot; it supplies also the back of the leg and a strip in the middle of the posterior surface of the thigh, and the saddle-shaped area, the perineum, scrotum and penis. The fourth cervical segment furnishes sensations down a line below the clavicle adjoining the distribution of the second dorsal. The absence of representation on the trunk of the intervening segments, is explained by the fact that in the budding and growth of the upper extremity the areas supplied by the 5th, 6th, 7th, and 8th, cervical and the first dorsal are carried down the arm.

For a similar reason the 12th dorsal closely approximates the third sacral on the buttock. Sherrington says: "It is probable that complete anesthesia in any area implies loss of the segments above and below the one which supplies that area, as each part of the body receives sensory fibres from these segments.

"In case the roots are crushed at the same level as the cord the anaesthesia will reach to the level of the lesion." Kocher calls attention to the strip of hyperaesthesia, which surmounts the anaesthesia and points to root irritation.

Incomplete anaesthesia signifies incomplete lesion of the cord.

Varying areas of anaesthesia also indicate incomplete lesion.

#### PAIN.

The pain in organic disease of the spinal cord is usually localized, and seldom varies in its localization.

Pain in the region of the 6th to 12th dorsal—posterior iliac, spine and coccyx should be differentiated from hypersensitive, hysterogenic zones.

Pain is never referred to a point above the seat of lesion; it is usually referred below the seat of lesion when nerve fibres alone are involved and at the seat of the lesion when the roots are implicated. Horsley says that the localization of pain tends to be too low. Development of sudden tearing burning pain ereeping rapidly up is caused by hemorrhage, either in the membranes or rarely in the cord.

The root pain, commonly called girdle pain, or sensation is significant of inflammation, or degenerate changes in the cord itself, and while the posterior nerve roots are in a state of irritation, yet this irritation differs from that commonly experienced in disease in the vertebrae as caries, or in growths like tumors, which irritate the conducting fibres. The girdle sensation is distinctive in that it is a painful feeling of constriction, of tightness or as one patient expressed it, that "his skin was too tight for his abdomen." This sensation is usually limited in width as it occurs in the locality just below the healthy region of the cord, where the damage portion begins. It is indicative of a transverse lesion of the cord, and is of localizing value.

Pain is not as frequent in traumatic lesions as in new growths. Pain of new growths is a root symptom—is burning, stabbing in character.

Posterior nerve roots are often diseased by degenerative processes that involve postero-external columns and give rise to similar and sometimes identical symptoms—with the exceptions that pain is often a prominent feature in nerve-root disease, the path for painful stimuli being contained in these roots, while it is open to question whether disease limited to the postero-external columns causes pain.

Posterior nerve roots when irritated cause hyperalgesic skin areas corresponding to the irritated roots.

The pain is often severe and persistent.

#### REFLEXES.

The study of reflexes is of great importance. In fact it may be said the condition of the reflexes is an index to diseases of the cord. This is explained by the fact that the entire reflex tract is limited to the peripheral or lower level neurones (the reflex tract or arc.) This tract or arc is made up of a sensory portion, contributed by the sensory peripheral neurone; a motor portion contributed by the motor peripheral neurone and a connecting link formed in the spinal cord by a branch of the sensory neurone known as the reflex collaterals. It is a short process of the posterior roots pass-



ing to the motor cells in the anterior horn. The cutaneous and tendon reflex arcs are the best known and the most simple while the more complex are not yet definitely known. The reflexes are important symptoms. If they are lost, diminished or exaggerated we know that ordinarily we may say that the cord, at least in the section under consideration, is diseased. The cutaneous reflexes vary with individuals so that when lost or diminished we cannot put too much reliance upon their value. The presence of the reflex, however, is of value as it shows an intact condition of the arc in the segments upon which it depends.

The knee reflex phenomena is of the most value clinically in spinal injuries. Immediately after a severe contusion to any part of the cord, the knee jerks may be very much diminished or unobtainable. If the injury is above the lumbar region, the absence of the knee jerk alone is not sufficient evidence for a total transverse lesion; for with the resorption of blood, and recovery from shock to the nerve-fibres and nerve-cells, the knee jerks, though they were absent at first, may return or become more exaggerated. If the knee jerks have not returned by the end of a week or ten days, however, it is certain that the lesion is extensive and severe. In lesions in the lumbar region and lower down, both in the cord and in the nerve-plexus, the knee jerk is less reliable as an index of the extent of the injury; for these regions are the seats of the knee jerks mechanism and even partial injuries here are very likely to destroy it. (Pearce Bailey.) The exaggeration of the knee jerk shows that the arc itself has not been destroyed but that the lesion is situated above the second and third lumbar segments and the exaggeration is due to cutting off the inhibiting cerebral impulses or that the gray substance of the cord is disturbed by inflammatory or trophic changes. Both causes may act in conjunction and produce very active exaggeration. The loss of the reflexes indicates disease in either anterior or posterior fibres or both. It is by noting the associated symptoms that the real significance of the absence of the knee jerk is ascertained.

In considering the value of reflexes of the cord it is well to call attention here to the Babinski reflex. Babinski called attention to the fact that in lesions of the pyramidal tract (the motor pathway) irritation of the sole of the foot produces extension of the great toe. The toe is extended instead of flexed which usually results in the plantar reflex. Other observers have confirmed the value of this reflex which is now regarded as reliable and always investigated in spinal cord cases, especially in differentiating organic disease. Walton says it may appear in spinal fracture when no other reflex is present.

Other reflexes and their significance as compiled by Golebiewski are:

1. Plantar reflex; contraction of the muscles of the foot on irritation of the sole. (Lower part of the lumbar enlargement.)
  2. Gluteal reflex; contraction of the gluteal muscles on irritation of the skin of the gluteal region, (fourth to fifth lumbar segments.)
  3. Cremaster reflex; retraction of the testicle on irritation of the skin on the inner surface of the thigh, (first lumbar segment.)
  4. Abdominal reflex; contraction of the abdominal muscles on irritation in the region of the linea alba, (eleventh dorsal segment.)
- The superficial reflexes are generally lost or diminished in spinal fracture and always lost in complete lesion. (Walton.)

Other neurologic symptoms associated and of value are: Ankle clonus is significant of profound organic change in the cord unless associated with evidences of neurasthenia or hysteria. The dissociation of sensation is said by Sachs (N. Y. Neurological Society Proceedings, Oct. 1, 1901.) to be an exceedingly valuable symptom as indicative of moderate involvement of the cord. It is a root symptom and not necessarily an indication of absolute involvement of the cord itself. Disturbance of the muscle sense as found in inco-ordination, purposeless movements, etc., when disturbed in traumatic cases especially when associated with articular and tendinous senses, indicates transverse lesion of the cord.

## LOCALIZATION BY SEGMENTAL LEVELS.

The cervical region, by reason of its having within its scope very important nerve centers it is rare that a lesion of any consequence is not followed by serious consequences. It is rare that a lesion of any consequence in the cervical region is not followed by serious results, by reason of its having within its scope very important nerve centers. In total transverse lesions death is sure to follow because involvement of the phrenic nerves and consequent respiratory paralysis. In partial lesions (unilateral) the phrenic nerve of one side is paralyzed and as a consequence respiration ceases on one side—the thorax does not move and no breath sounds can be heard, while the diaphragm lies higher than on the normal side. Another danger confronting the patient is that of hypostatic pneumonia from which recovery cannot be expected. Bruns and Winscheid say that in lesions of any part of cervical enlargement, erection of the penis is very frequent. Injury to the upper part of the cervical cord causes a spastic paralysis of all four extremities and the muscles of the head will be implicated. It may be said that the higher up the lesion the sooner death is to be expected in cervical injuries. Total transverse lesions of the fifth cervical segment cause complete loss of power of all muscles supplied by the brachial plexus. Albert in his recent work on Surgical Diagnosis in speaking of fracture in region of the brachial plexus says, "It must be emphasized that fractures in the region of the origin of the brachial plexus may cause complete paralysis of the lower portion of the body, and yet the upper extremities may escape all injury or, at best, merely suffer incomplete paralysis, for instance, of one arm or both forearms."

The following symptoms are common to all lesions of the cervical region of the cord:

1. Vaso-motor disturbances.
2. Oculopupillary symptoms.
3. Disturbances of reflex action.

Vaso-motor symptoms vary from slight flushing of the skin to very copious and continued perspiration which may involve the face when the lower cervical is injured.

Vaso-motor symptoms are common says Gowers, irrespective of the seat of the lesion. These changes are shown in slight disturbances of increased warmth of the limb or with changes to cold, pale and livid extremities. There is disturbance of the thermal injuries. Wagner and Stopel report very high temperature.

## OCULOPUPILARY SYMPTOMS.

Both pupils are affected in bilateral lesions and only one pupil and that on the same side in unilateral lesions. These changes are due to injury to the cervical sympathetic.

## LESIONS OF THE DORSAL REGION.

The following symptoms are found: Girdle pain, a hyperaesthetic zone corresponding to the level of the lesion; spastic paralysis of the legs, usually in extension, more rarely in flexion; patellar and ankle clonus; often marked so called spinal epilepsy; anaesthesia up to and including the diseased segment; always preserved and often increased cutaneous reflexes; variable disturbances of the reflex functions, difficult micturation with violent tenesmus, sometimes involuntary evacuation, frequently retention of urine or paradoxical ischuria; constipation, subsequently bedsores, cystitis, etc.

The symptoms of partial lesions of the cord, which are very persistent are: Disturbances of sensation; sensitiveness of the spine or the spinous processes; disturbances of mobility of the spine, frequently attended by inability to stoop; disturbances of gait.

Total transverse lesions of the dorsal region are usually fatal, death following either soon after the injury or later in consequence of lung or bladder complication. Partial lesions are not necessarily fatal as recoveries usually follow with persistent disturbances as before stated.

Lesions of lumbar and sacral region are shown principally in involvement of the cauda equina as the cord itself does not extend below the first lumbar vertebra; the symptoms vary with location and extent of the lesion. The phenomena of injury in this locality is usually uniform and distinctive.

The motor paralysis, involves the sciatic and pudic the anterior crural and obturator nerves. The paralysis varies in severity in consequence R. D. varies with the extent of the injury.

The anaesthesia follows the distribution of the great and small sciatic and pudic nerves.

When the fourth and fifth sacral roots alone are involved, then the anaesthesia is limited to the perineum, genitals and give rise to the saddle shaped area on the buttocks and thigh.

Sometimes it is difficult to get distinctive local indications and hence, it is not always possible to differentiate injuries to the cauda equina.

Herter gives as an aid, the following suggestions: "Anesthesia limited to the buttocks (saddle-shaped area) or to buttocks and back of the thigh, or to the buttocks, thigh and legs. (Posterior aspect) suggests cauda equina injury, also small loss of motor power with considerable sensory involvement suggests cauda lesion."

"Pain in the area of anesthesia points to cauda equina lesion and pain *above* the area of anaesthesia a cord lesion.

The pain of cauda injury is referred to the sacrum rather than to lumbar region.

When the cornu medullaris is involved it intensifies cauda lesions—causes paralysis of the bladder and rectal sphincter and loss of sexual power."

#### ANTERIOR ROOT SYMPTOMS.

Irritation anterior nerve root symptoms give rise to over activity.

The muscular areas involved corresponding to the segments involved.

Acute irritative lesions are marked; they may exist independent of motor paralysis.

#### ELECTRO-DIAGNOSIS.

The first essential to electro-diagnosis of cord lesions is a knowledge of the motor points. As each neurone is an independent unit, the degeneration is limited to the neurone or neurones so affected. The muscle fibres intimately connected with a peripheral neurone will degenerate with it. If, then, we elicit certain muscular phenomena of a pathologic nature by stimulating a nerve

at its known motor point, we at once distinguish this from a like pathologic condition of the central neurone. Knowing the point of emanation of each nerve from the cord, localization of the lesion becomes a simple matter.

Responses to electrical stimulation are of two kinds—motor and sensory. The first of these can be again divided into quantitative and qualitative. Quantitatively, we have increase of excitability or diminution of excitability. (1.) Increase of excitability is not of very great practical importance, as it indicates merely some actual molecular change of some part of the nervous system—either an irritation in the centres of the parts examined or a loss of the inhibitory influence of the brain upon peripheral tracts. Of affections of the cord, an augmented state of excitability is found occasionally in locomotor ataxia, in early stages of progressive muscular atrophy, and in single cases of transverse myelitis. (2.) Although diminution of excitability has been observed where the musculature has been rendered inactive for some time, from traumatic causes and in true muscular hypertrophies, as well as in polymyositis progressive, it is of little practical value because we have in the reaction of degeneration a surer means of diagnosis.

A degenerated muscle exists wherever we have a degenerated nerve. Such a muscle responds to electric stimulation with a pathologic reaction, known as the reaction of degeneration; the most important feature of which is the torpid quality of the muscular contraction upon galvanic stimulation. The seat of the pathologic condition producing R. D. is always the neuraxon and muscle, the nerve may be affected in any part of its course, i. e. spinal nuclei in the anterior horns, anterior roots and peripheral branches. R. D. is never present in pure muscular disease. R. D. is encountered in affections of the motor-nerve roots, in affections of the anterior horn cells and in progressive muscular atrophy of spinal origin. R. D. is always a sign of *organic* disease.

Sensory responses to electrical stimulation are of very slight value. However, in tabes there may exist a faradic analgesia without



any sensory loss to other forms of stimulation. These methods show us that a lesion is present, that it is not in the central neurone, but in the cord or its branches, and that it is in a certain definite locality.

#### DIFFERENTIAL DIAGNOSIS.

Whether lesion is partial or complete?

The symptoms of partial lesions according to Wagner and Stolper are:

1. Motor and sensory disturbances having an unequal distribution.

2. The two sides of the body are especially liable to be unequally affected (asymmetric paralysis.) I have seen one such case accompanying injury to the cord without apparent fracture.

3. There are signs of both motor and sensory irritability.

4. The patellar reflexes are present in almost all cases. They are usually exaggerated and are often unequal as to the two sides. (They are never permanently lost.)

5. Partial or complete restoration of functional power takes place within one or two weeks.

The symptoms of total transverse lesions as given by the same authors are:

1. Motor and sensory paralysis, equally marked on both sides of the body.

2. Loss of all nervous irritability in the region affected by the paralysis.

3. Loss of the patellar reflexes.

In addition we find:

4. Paralysis of bladder and rectum.

5. Vaso-motor paralysis.

#### DIFFERENTIATION BETWEEN DESTRUCTIVE AND IRRITATIVE LESIONS.

(Gray substance of the cord.)

##### DESTRUCTIVE.

Anterior horns.

1. Motor paralysis.

2. Degenerative atrophy.

3. Reaction of degeneration.

4. Loss of reflexus.

5. Absence of sensory symptoms. (If sensory symptoms are present it shows further involvement of the segment.)

Posterior horns. Destructive disease limited to posterior horns is rare, usually associated with irritative disease.

1. Loss of sensibility to pain and temperature doubtful if tactile sensibility or muscle sense are disturbed.

#### DIFFERENTIATION BETWEEN DESTRUCTIVE AND IRRITATIVE LESIONS.

(White substance of the cord.)

##### DESTRUCTIVE.

1. Loss of voluntary power below the level of the lesion.

2. No degenerative atrophy.

3. Excessive reflex action, increased knee jerks, often ankle clonus.

4. Spasm or rigidity of muscles below seat of disease.

Two clinical types of paralysis produced by destructive lesions according to location of lesion.

1. Atrophic spinal paralysis.

2. Spastic spinal paralysis. (The clinical features of these forms sometimes blend.)

#### POSTERO-EXTERNAL OF THE POSTERIOR COLUMNS OF THE CORD.

1. Inco-ordination in the extremities below level of the lesion.

2. Loss of tactile sensibility varying in distribution (usually chiefly in the legs) according to the vertical extent and position of the lesion.

3. Diminution or loss of reflex action (loss of knee jerk if the lesion is in the lumbar region.)

##### POSTERO-INTERNAL COLUMNS.

There is little clinico-pathological evidence of disease in this locality which is believed to give rise to disturbance of co-ordination or of equilibrium and may be masked by the inco-ordination which follows in lesions of postero-external columns.

#### UNILATERAL LESION.

(GOWERS' TABLE.)

Zone of cutaneous hyperaesthesia. Zone of cutaneous anaesthesia.	Lesion.	
Motor palsy. Hyperaesthesia of skin. Muscular sense impaired. Reflex action first lessened, then increased. Temperature raised.		Muscular power normal. Loss of sensibility of skin. Muscular sense normal. Reflex action normal.  Temperature same as that above lesion.

## SPINAL INJURIES.\*

BY CARL E. BLACK, M. D., JACKSONVILLE.

## EXPLANATION.

*Reasons for Presenting.* There are two principal reasons why the subject I have selected for this occasion merits further investigation and study.

*Development of Nervous System.* The first is that the spinal organ with its enveloping membranes and bony column, muscles, and tendons is anatomically of great importance. Their integrity is essential to the very existence of man. I cannot emphasize this point in any better way than by calling attention to the development of the vertebral column. It appears first and the other parts of the skeleton are developed around it. The spinal cord is the first part of the nervous system formed, the other parts being added to it or growing out from it. It is the basis of the nervous system.

*The Main Spring.* The cerebro spinal axis is the main spring of man's machinery. It is the great cable through which all the multitude of lines from the central station to every part of the body are carried. Just in proportion to the extent of injury to this cable will be the disabilities of the injured.

*Enormous Fatality.* The second reason for its importance is the enormous fatality of injuries of the spine, and the unsatisfactory results obtained by every and all forms of treatment. The reasons for prompt and energetic treatment of injuries of the spine are no less urgent than those for the treatment of similar injuries to the skull. It is a matter of common observation that the treatment of injuries of the spine have been attended by much less satisfactory results.

*Stimulate Discussion.* The purpose of this paper is to stimulate a discussion of methods of treatment with the hope of aiding in their improvement. I have no startling achievements to offer, but rather have been uniformly unsuccessful in the treatment of these cases.

*Have expectations been realized?* Not many years ago this field seemed to offer wonderful results to the investigator who would push boldly into every case. We hope to see whether or not these expectations have been realized, and whether the exploration, experimentation, and observation, which has been directed to spinal surgery, has in reality achieved the great results which the ambitious modern surgeon expected.

*Of interest to every physician or surgeon.* The subject is of peculiar interest because every physician, as well as every surgeon, will certainly, sooner or later, be called upon to treat a patient with a broken back or broken neck. These are terrible cases, followed by instantaneous paralysis, and the prospect of life long disability or speedy death.

*In its infancy—Scant literature.* Spinal surgery is undoubtedly in its infancy. A review of all the work done along this line comprises only a small quantity of medical literature. One reason for the comparatively slow progress of spinal surgery, aside from the mechanical difficulties involved, is the fact that the surgeon is only a secondary factor in the consideration.

*The Neurologist.* The major progress must be made by the neurologist. As far as practicable, I have invited the neurologist into active participation into all of my cases, and largely followed his advice. The neurologist must take the lead in developing the treatment appropriate to these cases. The uncertainty and doubt, which surrounds treatment of dislocations, fractures, gunshot wounds, and other injuries of the spine, can only be cleared up by the more careful and extended study and investigation of the functions and characteristics of the spinal cord, as well as the nature of these injuries.

*Can Operation Modify?* To what extent can operation be looked to to modify the gloomy prospect of these cases? Imperfect restoration to health rarely occurs, and perfect restoration to health almost never after fracture of any portion of the spine followed by paralysis. Occasionally a patient will completely recover. A little more fre-

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

quently they recover their health, the paralysis persists, and they spend the rest of their lives wheeling about in a chair or confined to their bed.

*Varieties.* For the sake of brevity the varieties of spinal injury are presented in tabular form. 1. Spinal Concussion. 2. Sprains of the Spine. 3. Dislocation of the Spine. 4. Fracture of the Spine. 5. Fracture-Dislocation. 6. Gunshot Wounds. 7. Stab Wounds.

Some authors classify injuries to the spine according to the region in which they occur, that is, cervical, dorsal, lumbar or sacral.

*Keen.* Keen says that 20 per cent of the spinal injuries are simple fractures, 20 per cent are simple dislocations and 60 per cent fracture dislocations. The classification leaves no room for the great number of spinal injuries unaccompanied by either fracture or dislocation, but which are equally severe and often fatal. It is therefore incomplete when applied to all spinal injuries.

I have purposely excluded spinal tumors, spinal tuberculosis with caries and necrosis of spinal vertebrae.

*Five Hundred and Fifty-two Cases.* According to my own study of 552 cases of spinal injury taken from the literature there were 17 per cent dislocations, 56 per cent fractures, 18 per cent gunshot wounds, 3 per cent concussions, and 2 per cent stab wounds.

#### LOCALIZATION.

*Neurological Studies.* Spinal surgery of today has been made possible by spinal localization. Without the studies of Starr, Mill, Thornburn, Keen, Bastian, Bowley, Herter, Abbe, Lloyd, Dana, Sachs, Jakob, and Gowers, Kocher and others that might be mentioned, modern surgery of the spine would yet be unborn.

*Each Segment a Unit.* Each segment of the spinal cord must be regarded as a unit possessing definite motor, sensory, trophic, vaso-motor and reflex functions, all which find expression in the peripheral distribution received from it or which returns to it.

*Named from the Nerves.* We must always bear in mind that a segment is not named from the vertebra which is level with it but

from the pair of nerves which rise from it.

*Peripheral Nerves.* Of course it must be remembered that a peripheral nerve may, and in fact usually does contain, sensory or motor fibers from several segments. A muscle may be capable of assisting in numerous movements and consequently have nerve fibers from several segments; also several muscles are usually concerned in any movement, therefore, a segment will supply fibers to more than one muscle.

*Groups of Muscles.* By discovering deficient action of a group or groups of muscles concerned in certain movements, and controlled by certain segments of the cord, one may determine which segment or segments of the cord has been injured.

*Dr. Norbury.* We must depend upon the neurologist to assist us in determining the location of injury, and the point at which operative interference will be most effective. This phase of the subject will be completely amplified by my colleague, Dr. Norbury.

#### SIGNS.

*Two Classes.* The signs of injury to the spine are of two classes. First, local signs, as (a) deformity, (b) mobility, (c) crepitus, (d) trophic changes, (e) interference with respiration.

*Position of Head.* The position of the head is a valuable sign in cervical luxation. If the dislocation is backward the head will be fixed upon the breast; if it is forward it will be extended or carried backward, while with a lateral dislocation the head will be turned to one side or the other.

*Deformity.* There may be deformity coming on immediately or perhaps not showing itself for several days. That is, those signs occurring along the spine as of depression of spinous process, deflexion or twisting of the spinal column. Sometimes a distinct knuckle is present instead of a depression.

*Infiltration, Tenderness, Pain.* These signs accompanied by infiltration of tissue, tenderness, and local pain are of great importance in making a diagnosis. It must be remembered, however, that the spinal column, as examined through the overlying tissues, is capable of great physiological irregularities, which may easily be mistaken



for signs of injury.

*Physiological Curves.* G. L. Walton, (The Journal of Nervous and Mental Disease, Jan. 1902) publishes some very interesting diagrams showing the variations in the dorsal curves in healthy students, furnished by Miss Amy Homans, of the Boston Normal School for Gymnastics. They indicate plainly that we should be on our guard regarding signs, and not be mislead for physiological irregularities.

*Disability.* Disability of the muscles of the back, inability to rise or perform certain bodily movements, pain on being rolled are signs which should lead us to suspect vertebral injury.

*Injury to Cord.* The second-class of signs are those produced by injury to the spinal cord itself.

*Paralysis.* Paralysis of the muscles of the extremities, and in fact of all parts below the injury, as of the rectum, bladder, absence of sensation below the injury.

*Reflexes.* Absence of reflex action, pain in certain muscles or extremities, hyperesthesia just above the anesthetic area are all signs which should lead to the closest scrutiny of the spine.

*Pain, Hyperesthesia, Anaesthesia.* In complete transverse dislocation of the column there will inevitably be below the level of the injury complete paraplegia and anaesthesia, obliteration of the reflexes, both superficial and deep, with paralysis of the rectum and bladder. If the lesion in the cord is more or less incomplete these phenomena will be proportionately incomplete or transient.

#### SYMPTOMS.

Symptoms following injury to the spine are of two classes, as before suggested regarding signs. First, those referable to bony column. Injury to the bony column with its tendons, muscles, ligaments, vessels, and nerves, and depend upon the character of the injury. They are, in general, disability, pain and shock.

*Spinal Cord.* Second. The most important class of symptoms are those referred to the spinal cord and its membranes, which, for convenience, may be divided into motor,

sensory, genito-urinary, rectal, respiratory, nervous, nutritive, and intellection.

*Common Symptoms.* While all the injuries to the spine possess many symptoms and signs in common, they differ widely according to the nerves which are injured or disturbed. Motor and sensory paralysis to the level of the seat of fracture may be complete or incomplete.

#### DIAGNOSIS.

*Concussion.* What has been said regarding signs and symptoms covers most of the points in arriving at the diagnosis of injury to the spine. The neurological diagnosis will be discussed by Dr. Norbury. The surgeon is chiefly concerned with the differentiation between concussion, dislocation and fracture. The diagnosis of concussion depends largely upon the absence of signs or symptoms indicating injury to the spinal vertebrae or the structures connecting the vertebrae. No doubt many cases, which are called concussion, really have a partial dislocation returning to the natural position spontaneously, or a slight fracture, or a serious strain of the ligaments as their basis.

The principal questions in these cases are to eliminate the existence of dislocation or fracture, and to demonstrate by neurological methods that injury to the spinal cord exists.

*Dislocation.* For many years, about the period from 1860 to 1875, there was a prolonged discussion as to whether dislocation without fracture ever existed. A number of prominent surgeons reported cases of pure dislocation without fracture. Many of these cases were demonstrated by post-mortem examinations. At the present time we are able to collect a large number of well authenticated cases of pure dislocation of the spine. The diagnosis in these cases depends on the history of injury, the existence of deformity, interference or non interference with the function of the cord, and the absence of the ordinary signs of fracture.

*Fractures.* Fractures of the spine are diagnosticated on the same principal as fractures of other parts of the body. There is history of injury, deformity, and crepitus accompanied in almost all cases by pain,

tenderness, swelling, and interference with the functions of the vertebral column and spinal cord.

*Gunshot wounds.* Gunshot wounds of the spine are diagnosed by the evidence of ball penetration, accompanied or unaccompanied by the signs of fracture and evidence of interference with the function of the cord.

Stab wounds of the spine have little significance excepting when accompanied by evidence of injury to the cord or its membranes. The point of the knife rarely injures a vertebra, but must pass between two vertebrae in order to enter the spinal canal.

*X-Ray.* The diagnosis of injuries to the spine would be incomplete without mentioning the use of the X-Ray. Many obscure cases can now be cleared up by this method. Quite a number of authors have reported cases in which good radiographs have been secured, showing the true nature of the lesion and the extent of its deformity.

I believe that the first radiograph of a spinal injury was made in 1900 by Robert Abbe. The case was one of dislocation of the axis upon the atlas to one side. The head was fixed in the characteristic position, but there was little pain and no paralysis. The X-Ray cleared up the diagnosis.

PATHOLOGY.

The gross pathology of injuries of the spinal cord is comparatively simple. There are two principal forms of lesion, which result from injury; compressing lesions, and destroying lesions.

*Compressing Lesions.* Compressing lesions are produced by dislocated vertebra, or parts of fractured vertebra lying against the spinal cord with sufficient force to compress it but at the same time not severing its fibers. The same may result from hemorrhage into the canal, forming clot, which compresses the cord. During the process of repair after fracture, bony callus may be thrown out and compress the cord. There may be thickening in the membranes or an effusion of serum of sufficient amount to compress the cord.

*Destroying Lesions.* Destroying lesions usually result from dislocation, fracture, gunshot wounds, or stab wounds. Anything

which opens the membranes and enters the cord structure is a destroying lesion by just as many fibers as are injured. Only a few bundles of fibers may be injured or the whole cord may be severed. One point which seems to have been overlooked by many writers, is that a very small destruction of spinal tissue is proportionately very great when compared with a destruction of tissue in the brain. For this reason spinal injuries are always proportionately much more severe than cerebral injuries.

It has been my fortune, or misfortune, to treat a number of cases of injury to the spine. The treatment of these cases has aroused the most intense interest in the subject, and lead me to search the literature for cases similar or different from those which I had seen. Within the past year I have made a study of 552 cases, taken mostly from current medical literature.

My special purpose has been to try to discover whether or not operations have increased the chances of recovery. I give you the results of these studies. I have divided the cases into those which were operated and those which were not operated; indicating the total number of cases; the number recovered; the number died; the number unimproved and the number in which the ultimate results were not stated. We will first classify the cases according to variety of injury.

CONCUSSION OF SPINE.

Region.	No. of Cases	Operated.				Not Operated.			
		Recov- ered.	Died.	Unim- proved	Not stated.	Recov- ered.	Died.	Unim- proved	Not stated.
Cervical.....	8	...	1	...	...	1	5	...	1
Dorsal.....	17	5	1	1	...	6	4	...	...
Lumbar.....	12	...	1	...	...	1	2	...	...
Region not stated.	5	...	...	...	...	5	...	...	...
Totals.....	34	5	3	1	...	13	11	...	1
Summary .....		9				25			

Of the 34 cases of concussion reported in the above table, nine were operated, of which 5, or 55 per cent recovered and 25 were not operated, of which 13, or 52 per cent recovered. The numbers are all too small to lead to any fair conclusion. The slight favor, however, is on the side of operation.

## DISLOCATION OF SPINE.

Region.	No. of Cases	Operated.				Not Operated.			
		Recov- ered.	Died.	Unim- proved	Not stated.	Recov- ered.	Died.	Unim- proved	Not stated.
Cervical.....	72	19	3	...	...	8	39	2	1
Dorsal.....	15	5	1	2	...	1	7	...	...
Lumbar.....	4	2	1	...	...	1	...	...	...
Totals.....	93	26	6	2	...	10	46	2	1
Summary .....		34				59			

Many of these cases of dislocation were verified by post-mortem as being true simple dislocations, and as far as I can judge from the reports, none of them give signs or symptoms of accompanying fracture. It is necessary to explain that I have included, as an operation for dislocation all cases in which a serious attempt was made to reduce the dislocation. I did not deem it necessary to limit the operative cases to simply those in which the spinal vertebrae were exposed by an incision; although some of the dislocations were treated in that way.

In these cases you will notice that of the 34, in which the dislocation was reduced either by the open method or manipulation, 26 or 76 per cent recovered, while in those cases in which no attempt was made to reduce the dislocation, or in which manipulative attempts failed, and open operation was not made, only 10 or 17 per cent, out of 59 recovered, giving an enormous mortality of 78 per cent.

## FRACTURES OF THE SPINE.

No. of Vertebra.	No. of Cases	Operated.				Not Operated.			
		Recov- ered.	Died.	Unim- proved	Not stated.	Recov- ered.	Died.	Unim- proved	Not stated.
1st.....	12	...	1	...	...	1	10	...	1
2nd.....	7	1	1	...	...	...	4	...	...
3rd.....	5	2	1	...	...	...	8	...	...
4th.....	16	13	3	1	...	12	3	1	...
5th.....	29	13	3	...	...	2	17	2	...
6th.....	14	5	3	...	...	1	8	...	...
7th.....	6	...	...	...	...	1	3	...	...
Unknown.....	5	...	1	...	...	2	3	...	...
Totals.....	94	8	20	1	...	9	52	3	1
Summary .....		29				65			

Dorsal.	1st.....	6	1	1	.....	.....	2	2	.....	
	2nd.....	3	1	1	.....	.....	1	.....	.....	
	3rd.....	5	2	1	.....	.....	2	.....	.....	
	4th.....	7	2	1	.....	.....	3	.....	1	
	5th.....	3	1	2	.....	.....	.....	.....	.....	
	6th.....	9	4	1	2	.....	2	.....	.....	
	7th.....	12	5	3	1	.....	3	.....	.....	
	8th.....	7	2	2	1	1	2	1	1	
	9th.....	8	3	2	1	1	1	.....	.....	
	10th.....	18	9	4	.....	.....	2	3	.....	
	11th.....	17	7	7	3	.....	.....	.....	.....	
	12th.....	45	12	18	2	5	7	.....	1	
	Unknown.....	14	4	4	.....	.....	1	4	1	
Totals.....		154	51	47	9	7	11	20	5	4
Summary.....		114					40			
Lumbar.	1st.....	18	7	2	3	.....	1	5	.....	.....
	2nd.....	9	3	2	.....	.....	4	.....	.....	.....
	3rd.....	3	1	.....	.....	.....	2	.....	.....	.....
	4th.....	5	1	.....	.....	.....	1	2	1	.....
	5th.....	1	.....	.....	.....	.....	1	.....	.....	.....
	Unknown.....	8	2	1	1	1	1	1	.....	1
Totals.....		44	14	5	4	1	9	9	1	1
Summary .....		24					20			
Sacral.....		2	2	.....	.....	.....	.....	.....	.....	.....
Sacral-coccygeal .....		1	1	.....	.....	.....	.....	.....	.....	.....
Region not named .....		16	.....	.....	1	.....	10	3	1	1
Totals.....		310	76	72	15	8	39	84	10	7
Summary .....		170					140			

I call your attention to several interesting points brought out by the above tabulation of 310 cases of fracture of the spine in all regions. These cases are tabulated by the highest vertebra injured. In many of the cases more than one vertebra was fractured. The 4th, 5th and 6th cervical were injured 59 times, while the 2d, 3d and 7th cervical were only injured 23 times. The atlas was injured 11 times. This shows a remarkable election for the 4th, 5th and 6th cervical.

In the dorsal region the point of election is still more prominent. More than one-half (80) of the dorsal fractures occur in the 10th, 11th or 12th vertebra.

In the lumbar region a little less than one-half (18 out of 44) of the injuries occurred in the 10th, 11th or 12th vertebra.

More than one-half of all the injuries of the 24 vertebrae in the cervical, dorsal, and lumbar regions occur in two well defined localities. The first includes the 4th, 5th and 6th cervical and the last includes the 10th, 11th and 12th dorsal and first lumbar.

Of the 310 fractures in all regions 170 were operated, and 140 were not operated.



Of the operated cases 76, or 44 1-2 per cent recovered and regained their functions, 15, or 8 per cent, recovered from the operation, but were unimproved by it, and 72, or 42 per cent died. Of the 140 cases which were not operated only 39, or 27 per cent recovered; 10, or 7 per cent, lived but did not improve in function, and 84, or 60 per cent died. Thus of all fractures in all regions there is a balance of 18 per cent in favor of operative interference, and an improvement of 18 per cent in mortality.

GUNSHOT OF SPINE.

No. of Vertebra.	No. of Cases	Operated.				Not Operated.			
		Recov- ered.	Died.	Unim- proved	Not stated.	Recov- ered.	Died.	Unim- proved	Not stated.
Cervical.	1st.....	4	1	1	.....	.....	1	.....	.....
	2nd.....	4	1	.....	.....	.....	.....	.....	.....
	3rd.....	4	1	1	.....	.....	.....	.....	.....
	4th.....	5	1	1	.....	.....	.....	.....	.....
	5th.....	3	2	2	.....	.....	1	.....	.....
	6th.....	3	.....	.....	.....	.....	1	.....	.....
	7th.....	3	.....	.....	.....	.....	1	.....	.....
	Unknown.....	3	1	1	.....	.....	1	.....	.....
Totals.....		31	7	8	.....	1	15	.....	.....
Summary....		15				16			
Dorsal.	1st.....	3	1	1	.....	.....	1	.....	.....
	2nd.....	4	.....	.....	.....	.....	4	.....	.....
	3rd.....	3	.....	.....	.....	.....	.....	.....	.....
	4th.....	3	.....	.....	.....	.....	1	.....	.....
	5th.....	3	.....	1	.....	.....	1	.....	.....
	6th.....	3	.....	.....	.....	.....	1	.....	.....
	7th.....	3	.....	.....	.....	.....	1	1	.....
	8th.....	5	2	.....	.....	.....	3	.....	.....
	9th.....	3	.....	1	.....	.....	3	.....	.....
	10th.....	5	1	.....	.....	.....	3	.....	.....
	11th.....	4	.....	.....	.....	.....	2	.....	.....
	12th.....	3	.....	3	.....	.....	4	1	.....
	Unknown.....	4	1	.....	.....	.....	3	.....	.....
Totals.....		49	5	16	.....	2	24	2	.....
Summary.....		21				28			
Lumbar.	1st.....	4	2	1	.....	.....	1	.....	.....
	2nd.....	4	1	1	.....	.....	2	.....	.....
	3rd.....	2	.....	1	.....	.....	1	.....	.....
	4th.....	4	1	.....	.....	.....	2	1	.....
	5th.....	.....	.....	.....	.....	.....	.....	.....	.....
Unknown.....		3	.....	.....	.....	2	.....	1	.....
Totals.....		17	4	3	.....	2	6	2	.....
Summary....		7				10			
Sacral.....		2	2	.....	.....	.....	1	2	.....
Region not named.		5	2	.....	.....	.....	.....	.....	.....
Totals.....		104	20	27	.....	5	46	6	.....
Summary.....		47				57			

Gunshot injuries of the spine show still more remarkable results from operative interference. Of 47 operated cases studied 20, or 42.2 per cent recovered and 27, or

57.4 per cent died. Among the 57 gunshot injuries which were not operated, only 5, or 9 per cent recovered; 46, or 80 per cent died, and 6, or 10 per cent lived with loss of function.

STAB WOUNDS OF SPINE.

Region.	No. of Cases	Operated.				Not Operated.			
		Recov- ered.	Died.	Unim- proved	Not stated.	Recov- ered.	Died.	Unim- proved	Not stated.
Cervical.....	5	1	.....	.....	.....	1	.....	.....	3
Dorsal.....	5	1	.....	.....	.....	1	.....	.....	.....
Region not stated.	3	.....	.....	.....	.....	2	1	.....	.....
Totals.....	13	2	.....	.....	.....	6	2	.....	3
Summary.....	2				11				.....

There are too few cases (only 13) of stab wounds to lead to any conclusion. Only two were operated and both recovered. Of the cases not operated the larger majority also recovered.

The following tables give the results by regions of the cord, and furnish some interesting data.

INJURIES TO THE SPINE BY REGIONS.

CERVICAL.										
Nature of Injury.	No. of Cases	Operated.				Not Operated.				
		Recov- ered.	Died.	Unim- proved	Not stated.	Recov- ered.	Died.	Unim- proved	Not stated.	
Concussions.....	8	.....	1	.....	.....	1	5	.....	1	
Dislocations.....	72	19	3	.....	.....	8	39	2	1	
Fractures.....	94	8	20	1	.....	9	52	3	1	
Gunshot injury.....	31	7	8	.....	.....	1	15	.....	.....	
Stab injury.....	5	1	.....	.....	.....	1	.....	.....	3	
Totals.....	210	35	32	1	.....	20	111	5	6	
Summary.....	68				142					
DORSAL.										
Concussions.....	17	5	1	1	.....	6	4	.....	.....	
Dislocations.....	17	5	2	.....	.....	1	7	.....	.....	
Fractures.....	154	51	47	9	7	11	20	5	4	
Gunshot injury.....	49	5	16	.....	.....	2	24	2	.....	
Stab injury.....	5	1	.....	.....	.....	3	1	.....	.....	
Totals.....	242	67	66	12	7	23	56	7	4	
Summary.....	152				90					
LUMBAR.										
Concussions.....	2	.....	1	.....	.....	1	.....	.....	.....	
Dislocations.....	4	2	1	.....	.....	1	.....	.....	.....	
Fractures.....	44	14	5	4	1	9	9	1	1	
Gunshot injury.....	17	4	3	.....	.....	2	6	2	.....	
Stab injury.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	
Totals.....	67	20	10	4	1	13	15	3	1	
Summary.....	35				32					

SACRAL AND COCCYGEAL.

Fractures.....	3	3	.....	.....	.....	.....	.....	.....
Gunshot.....	2	9	.....	.....	.....	.....	.....	.....
Totals.....	5	5	.....	.....	.....	.....	.....	.....

REGION NOT STATED.

Concussion.....	7				5	2		
Dislocation.....								
Fracture.....	16		1		10	3	1	1
Gunshot injury.....	2	2						
Stab injury.....	3				2	1		
Totals.....	28	2	1		17	6	1	1
Summary.....		3			25			

The above tables give summaries of all injuries of the spine by regions. Of the 552 cases, 210, or 38 per cent occurred in the cervical region: 242, or 44 per cent occurred in the dorsal region: 67, 12 per cent, occurred in the lumbar region, and 5, or 1 per cent occurred in the sacral and coccygeal region. In 28 cases, or 5 per cent the region was not stated.

*Cervical.* Of the 210 cases occurring in the cervical region 68 were operated and 142 were not operated. Of the operated cases 51 per cent recovered and 47 per cent died. One case was unimproved. Of those not operated 15 per cent recovered and 78 per cent died: 5 cases unimproved, and in 6 the result was not stated. You will notice that of all cases in the cervical region that the per centage of recoveries among the cases operated is nearly four times as large as in the cases not operated. Of the whole number of cervical injuries, 26 per cent recovered, and 68 per cent died. The others were either unimproved or the result was not stated.

*Dorsal.* In the dorsal region 152 cases were operated and 90 cases were not operated. Of the operated cases 44 per cent recovered, and 43 per cent died. In the cases not operated 20 per cent recovered and 62 per cent died. You will notice that in this region the percentage of recoveries among the operated cases is just about twice as large as it is in the cases not operated. Of the whole number of cases occurring in the dorsal, 37 per cent recovered and 50 per cent died. The others were unimproved, or the ultimate result was not stated.

*Lumbar.* Of the 60 cases in the lumbar

region 34 were operated, and 32 were not operated. Of the operated cases 55 per cent recovered, and 27 per cent died. Of the cases not operated 40 per cent recovered and 46 per cent died. This makes a difference of 15 per cent in favor of operations. Of all cases occurring in the lumbar region 53 per cent recovered and 41 per cent died. The others were either unimproved or the ultimate result was not stated.

*Sacral.* In the sacral regions there were only five cases, all of which recovered under operation.

As you will see from statistics given further along these percentages are somewhat at variance with those published by some other observers, in that the percentage of recovery is slightly higher in the cervical region than in the dorsal. This no doubt is due to including cases of dislocation treated by manipulation, otherwise the percentage of recoveries would be slightly lower. Naturally the percentage of recovery in the lumbar region is higher than in either of the others.

ALL REGIONS AND ALL INJURIES.

Region.	No. of Cases	Operative.				Not Operative.			
		Recover- ed.	Died.	Unim- proved	Not stated.	Recover- ed.	Died.	Unim- proved	Not stated.
Cervical.....	210	35	32	1	.....	20	111	5	6
Dorsal.....	242	67	66	12	.....	23	56	7	4
Lumbar.....	67	20	10	4	1	13	15	3	1
Sacral & coccyge.....	5	5	.....	.....	.....	.....	.....	.....	.....
Not stated.....	28	12	.....	1	.....	17	6	1	1
Totals.....	552	129	108	18	8	73	188	16	12
Summary.....		263				289			

*Operated.* The last table gives the summary of all injuries in all regions. There were 552 cases studied, of these 261 were operated and 289 were not operated. Of the operated cases 49.2 per cent recovered, both as to life and function, 6.8 per cent recovered from the operation, but had no improvement in function: of all cases 56 per cent survived the operation and 40 per cent died. In 8 cases the result was not stated.

*Not Operated.* Of all the 289 cases not operated only 25 per cent recovered both life and function, 6 per cent lived with loss of function, and 65 per cent died, and in 12 cases the ultimate result was not stated.

These studies seem to indicate that in all

cases of spinal injury the mortality can be reduced about 25 per cent by operation. I had intended to make a table giving a somewhat detailed report of each of the 552 cases studied, but the space allowed for such a paper will not permit.

The following statistical facts are taken from the literature and are of interest for comparison with the new tables which I have presented.

*Baldwin.* Those in the cervical region, according to the collection of cases made by Baldwin in the Massachusetts General Hospital (36 since 1870), all of which died.

*Courtney and Kocher.* Courtney and Kocher's (12 cases, all died—average life, one week.) The average duration of life was five days, excepting in Kocher's cases.

This differs widely from my case of fracture of the cervical, in which the patient lived eight weeks, and my case of gunshot injury of the cervical, in which the patient lived nearly two weeks. These also differ widely from my tables which show for all cervical injuries a mortality of 68 per cent.

In the dorsal region, we find a better state of affairs.

*Burrell. Gault.* Burrell's collection of the Boston City Hospital cases, occurring in the dorsal and lumbar regions, shows a fatality of 79 per cent (82 cases), and Gault, 80 per cent in 270 cases.

*Lloyd.* Lloyd presents a study of 104 cases of fracture, with a fatality of about 50 per cent in cases operated.

*Chipault.* Chipault's operative cases showed a fatality of about 40 per cent.

*Thornburn.* Thornburn's a fatality of 57 per cent.

*Walton.* Walton reports the cases operated on at the Massachusetts General Hospital since 1870 (15), with a fatality of 66 2-3 per cent.

*Monroe.* He adds to these Dr. Monroe's cases (13), with ten deaths. Walton therefore places the operative fatality at 70 per cent.

*Manley.* Thos. H. Manley says "I have seen, during the past twelve years, many cases of spinal lesions from traumatism, ending mostly in death, in which, though a few improved, none have thoroughly re-

covered who had complete paraplegia on admission to the hospital." He denies emphatically that the spinal cord is as accessible as the brain, or may be explored with as much impunity.

*Robert Abbe.* Robert Abbe thinks the immediate signs and symptoms of fracture with paraplegia give fairly accurate data for prognosis. The recoveries from operative interference in the cervical region have been exceedingly few. It should be remembered, however, that we can only give an imperfect prognosis, even in cases in which the diagnosis is clear. Slight hemorrhage into cord substance may give rise to serious symptoms which would be entirely beyond the reach of surgery, and yet ultimately recover.

*Percival R. Bolton.* Percival R. Bolton summarizes as follows: "The cells and fibers of the cord are easily destroyed and are never regenerated. Extradural hemorrhage causes no symptoms and needs no treatment. Total lesions of the cord are irreparable. In hematomyelia the clot is absorbed, its site persisting as a cavity, and no treatment, will improve the condition. After partial contusion of the cord, permanent destruction of cells and fibers takes place, and no treatment is of avail. In open injuries of the cord destruction of cells and fibers takes place."

*Stimpson.* Stimpson fully disagrees with Bolton's position, and calls attention to the importance of making the distinction between crushing the cord and hematomyelia. The former is hopeless, but the latter may be recovered from.

*Curtis.* Curtis disagrees with Bolton regarding extradural pressure, stating that he had removed a blood clot which was making pressure on the cord, and which was the cause of paralysis. The least unfavorable condition which we can have with paraplegia is hemorrhage outside of the cord. There is certainly no way to tell in advance whether the paraplegia is from a removable cause. In general, the nearer the injury is to the medulla, the sooner death supervenes, those at the base dying instantly, or within a few hours.

*Cheyne and Burchard.* Cheyne and Burchard consider fractures of the body of the



vertebrae much more serious than fractures of the arches.

*Genet.* Genet reported 270 cases, with 53 recoveries—all of these were operative cases. Our prognosis, therefore, depends partly on the situation of the injury, but largely on the character and extent of the injury to the spinal cord and its membranes.

*Olliver.* Olliver considers gunshot injuries more serious, and that death supervenes more rapidly than in those from other causes.

*Ashurst.* Ashurst gives some interesting figures from military surgery, of the 32 cases of vertebral fracture among the British soldiers in Crimea, all proved fatal except four, 'which were either fractures of the transverse process in the neck, or of the spinal processes only,' and in the French army, 181 died out of 194 (93.3 per cent.) In the war between Prussia and Hanover, in 1866, there were eight cases with six deaths.

Of 628 cases tabulated by Otis, 349 or 55.57 per cent. ended in death, the mortality according to locality having been: for the cervical region, 70 per cent. (63 out of 90): for the dorsal region, 63.5 (87 out of 137): and for the lumbar region, 45.5 per cent (66 out of 145): but in almost all, probably, of the non-fatal cases, the fractures affected only the processes. Of the subjects of lumbar injuries, 79 recovered, but it is expressly stated that "there were more than seventy recoveries after gunshot fractures of the apophyses of the lumbar spine." In circular No. 6, S. G. O., 1865, it is reported that "of 187 recorded cases of gunshot fracture of the vertebrae, all but seven proved fatal. Six of these were fractures of the transverse or spinous apophyses." Of 54 cases in which it is known that there was an associated injury of the cord, 42 died (77.78 per cent.") Ashurst, vol. 2, p. 205.

#### TREATMENT.

*Statistics.* These statistics should be of material assistance to us in determining the best line of treatment to pursue in a given case. After making several consecutive laminectomies for fracture and gunshot wounds of the spine, and seeing all die in from two days to six weeks, I felt very

skeptical about the value of operative interference.

*Favor Operation.* This stimulated me to look the subject up more fully. The tables herewith presented are the result of that study. The cases were taken from literature just as they came to hand. In fact I made no preliminary estimates until all cases were collected and tabulated; the result as you have already seen, is very largely in favor of operative interference.

*Exploratory.* Such operations must be considered, for the present at least, as exploratory operations. They must be made on that theory. I do not expect to speak of the technique of operating at the present time, but only to call attention to the reasons for operating.

*Mechanical Cause.* In severe injury to the spine we have a direct mechanical cause operating to compress or lacerate the spinal cord. It seems evident, that while we may be able from the symptoms and signs to form some estimate as to the extent of the trauma to the cord, we have no means by which we can be positive as to whether we have a compressing or a destroying lesion. Until the neurologist points out symptoms or signs by which the condition of the cord can be accurately known we must resort to exploratory procedures; hence the great value of these statistics.

*Expectant Plan.* We know that of a large number of cases of spinal injury, if one-half are treated expectantly and the other half treated by active interference, that while the mortality will be high in both, it will be fully twice as high as in those treated by the expectant plan. Therefore, I wish to enter an earnest plea for early exploratory operation in these cases. If we wait too long the cord will be injured beyond hope of repair. The sooner a compressed cord, or one slightly or partly lacerated is released, the better the chances of the patient for recovery.

In these cases we are dealing with desperate conditions, and the patient should be advised and urged to take desperate chances. We should not be moved by our personal experiences in the few cases which come to our hands, but look at each case from the

broader view given by analysis of a large number of cases. Let us fully realize that early, complete operation will save twice as many patients as the waiting or expectant plan.

### MOVABLE KIDNEY.

BY L. BRANNON, M. D., JOLIET, ILL.

Medical literature shows that abnormal mobility of the kidney was recognized and discussed by medical writers centuries ago. Since that time numerous methods of treatment have been proposed, though none received so much attention as the operative, which was introduced by Hahn in 1881. Since then, his method and many others have been practiced extensively. The results have not always been satisfactory, though in many instances they have been most gratifying, and the mortality has been small.

Authorities claim that the failures were due to the selection of improper cases, and the imperfect methods of operating. In reference to the first point, Henry Morris in his text-book on Surgical Diseases of the Kidney and Ureter, Vol. II, says:

"The opinions and practice of different surgeons are still greatly at variance. That such differences exist shows either that there are several methods pretty equally successful, or that no one method has such distinct or superlative advantage over the others as to have universally or even widely commended itself in preference to the rest.

"In one particular, however, all operators are agreed, namely, that the original plan of Hahn, and every modification of it whereby only the perinephric tissue—the fibro—fatty investment of the kidney—is shortened and fastened to the parietes, is useless or at any rate uncertain, and therefore unsatisfactory. Probably in one other particular all or most surgeons whose experience is large enough to give weight to their opinions would agree, namely, that permanent not temporary sutures are requisite, by which I mean sutures which will remain buried in the tissues and are not removed at the end of ten, twelve, or fifteen days."—Pages 221 and 222.

"The Operation. The different methods of

fixing the kidney now in vogue may be divided into two chief classes:

A. Those in which the partial decortication or stripping off of the capsule of the kidney forms part of the process.

B. Those in which no decortication is practiced.

In the first class the sutures (a) transfix the parenchyma of the kidney (Tuffier, Jonnesco; and in a very modified way the principle of decortication is acted upon in Bruce Clark's method); or (b) penetrate only the deflected flaps of the capsule (Newman, Jacobson, Lane, Law, Edebohls).

"In the second class the sutures are employed in three different ways: (a) They simply under-run the middle three-quarters of the capsule on the posterior aspect of the kidney (Vulliet); (b) They are made to pass the whole thickness of the kidney (Albarán); (c) They are made to pass in a curvilinear manner through only part of the thickness of the parenchyma (author's method).

"In addition to the differences in practice with reference to the insertion of the sutures into the kidney, there are differences with reference to their attachment to the parietes; some surgeons fixing the upper sutures to the last rib, others fixing all into the deeper layers, and others again, to the more superficial structures of the loin."—Page 222.

In reference to the second point, the selection of cases that are likely to be benefited by an operation, it is well known that the highly nervous and hysterical are the most uncertain, for in them it is difficult to tell whether the nervous symptoms are due to an inherited tendency or to the movable kidney. However, authorities recommend operative treatment in this class, when belts, bandages and all other palliative means have been tried and found insufficient to afford relief. It is generally understood that operative treatment is not justifiable, in the class in which the movable kidney gives rise to no inconvenience.

The symptoms of movable kidney are so thoroughly discussed in text-books that their mention here will be sufficient. Pain which may be constant and at times very severe, back-ache, dragging in the loins, gastritis, irregularity of the bowels, numerous nervous

symptoms, and in some cases changes in the urine. Septic symptoms appear in cases complicated with pyonephrosis. In some cases, at times, a movable kidney can be detected and outlined by palpation. This being the best proof, it is unfortunate that it cannot be done in all cases and at all times.

The principle troubles that existed in the five cases which I have treated by operation, were pain, more or less continuous, paroxysms of renal colic, gastric disturbances, nausea, vomiting and many symptoms of hysteria and neurasthenia. In four of the cases the results were entirely satisfactory. The other case was not under observation long enough to determine what the effect will be.

The kidneys were all anchored in the same manner, by suturing the capsule and parenchyma and scarifying the capsule included in the stitches. In each case the beginning of the ailment dated back to an injury, consequently the details of the last case will include points of interest of all this series, for, as has been stated, their symptoms were about the same.

The case mentioned is that of Mr. T.—, who was operated upon in the St. Joseph Hospital, and was referred to me by Dr. Curtis. His illness began six years ago and followed a blow that he received in the pit of the stomach from a kick by a horse. Immediately after receiving the injury he was taken very sick, and was confined to his bed for very weeks. From this time to January, 1902, the time of his operation, he complained of gastro-intestinal disturbances and pain in the back, which became excruciating, and required large doses of morphia. Later on these paroxysms of pain became more severe and occurred more frequent. Hysteria developed and on several occasions, shortly before the operation, chloroform anesthesia was resorted to in order to relieve his distress. His gastro-intestinal symptoms were well pronounced. His appetite was poor and even with a restricted diet he was troubled with flatulence, pyrosis and hiccough. With a heavier diet, was nauseated and vomited frequently. Periods of constipation were followed by diarrhea.

Briefly stated his nervous symptoms and

general condition went from bad to worse until he was an invalid. With the fixing of the kidney, improvement commenced and within a few months he was able to do farm work, and is now in good health.

## PROCEEDINGS OF STATE SOCIETY.

Minutes of the Fifty-Second Annual Meeting held at Quincy May 20-22, 1902.

The report of the Committee on Neurology was then read by O. B. Will.

**Dr. Christian Fenger.**

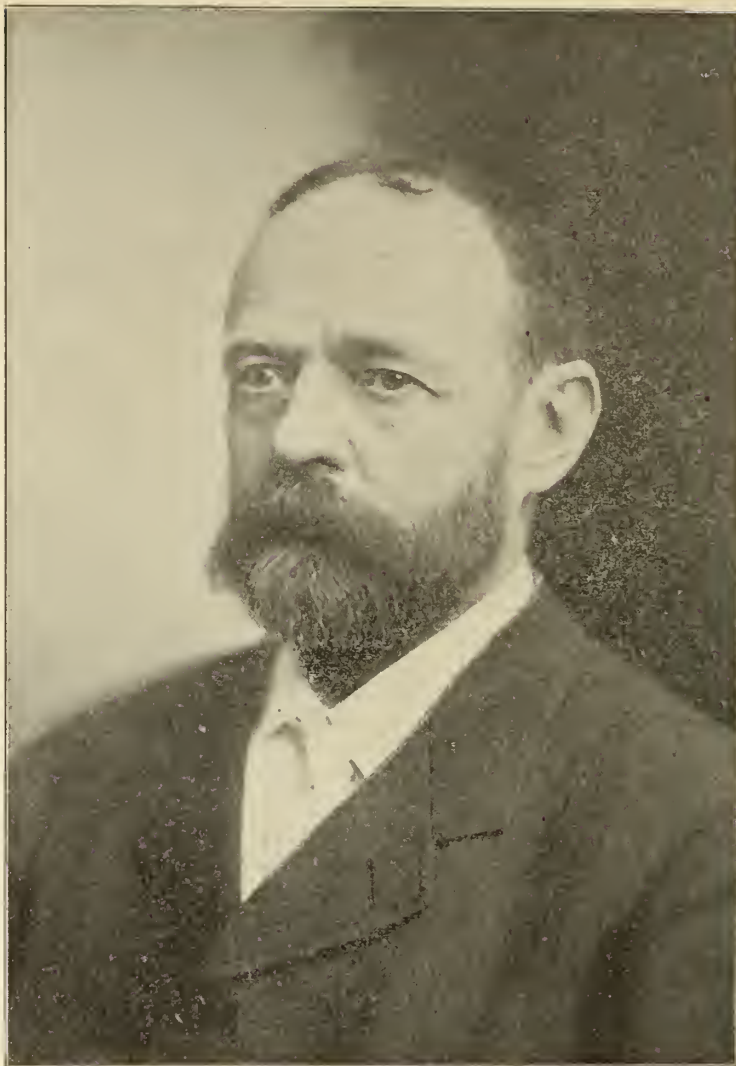
In the death of Christian Fenger, of Chicago, on March 7th, 1902, not only the medical profession of Illinois, but of the world, lost one of its brightest lights. The representative society of his state was honored by his membership, and was many times the arena of his valuable demonstrations, clinical and didactic.

During the period that has elapsed since the death of Dr. Fenger, opportunity has fallen to the lot of the public and periodic medical press and various local societies, to eulogize him, and in every instance has been shown the same unstinted praise of his technical learning, his sterling manhood, his indefatigable energy, his helpful character and his noble devotion to the cause of science and humanity. These have built to his memory a monument in the minds and hearts of his professional brethren and the public at large, more enduring in its influence for good than any pile of marble or granite.

The work of Dr. Fenger speaks for itself, not only in the impress he has made on the literature of his time, but in the inspiration he has directly given to hundreds of young men who have listened to the words of wisdom dropped from his lips and watched with increasing interest the deft manipulations of his magic touch, the thoroughness and pains-taking character of his demonstrations, and his conscientious regard for truth and accuracy.

Probably no man living ever made a more zealous effort than did Dr. Fenger to properly equip himself for a systematic pursuit of the necessary intricacies of his calling.





*Christian Fenger*

Coming upon the stage of action when he did, he was one of the few who quickly discerned the changing tide in surgical pathology and therapeutics, and adapted himself at once to the unlearning of much that he had been taught. The anti and aseptic regime in its inception found him not only a willing student, but one fully equipped in learning and logic to help on the work of progress. Thus he became an original exponent of scientific and practical ideas, and never re-

linquished his ardor to the day of his death.

As a practitioner Dr. Fenger was marvellously thorough and successful. As a teacher, clear, systematic, and beloved by his pupils. As a writer, he was plain and direct, and so widely acknowledged was his veracity that none cared to question his statements.

The leading facts of Dr. Fenger's life and work have since his death been so oft quoted as to have become familiar to all, and we

need therefore in this connection to make but a brief record of them. Anything like a history of his professional achievements would fill a volume, and to those interested in his technical work his published writings offer the richest result of honest endeavor.

Born in Copenhagen, Denmark, in 1840, Dr. Fenger pursued both his preliminary and medical studies in that city, and was in 1867 graduated from its university. He was assistant in Meyer's Ear Clinic for a time, and then served two years as interne in the Royal Frederick Hospital. He then engaged in practice until the Franco-Prussian war, through which he served as surgeon in the International Ambulance Association. He subsequently returned to his native city and for three years acted as prosector of surgery in the thousand bed city hospital. After presenting a remarkable thesis on "Cancer of pathological anatomy in the University.

In 1875 Dr. Fenger left Copenhagen and went to Egypt and became a member of the Sanitary Council of Alexandria. In 1876 he removed to Cairo and was appointed by the Khedive medical officer of the Khalifa quarter. In 1877, by reason of ill-health, he left Egypt and came to America, settling in Chicago, where he rapidly assumed position in the front rank of American surgeons.

For years Dr. Fenger occupied the chair of principles of surgery in the Northwestern University medical school, and subsequently became professor of clinical surgery at Rush Medical College, a position he held at the time of his death. He was also professor of surgery in the Chicago Policlinic, surgeon-in-chief of the German Hospital, attending surgeon at Passavant Hospital, and consulting surgeon to the Cook County, Provident, Tabitha and Baptist Hospitals. He was also a member (in 1896 vice-president) of the American Surgical Association, Illinois State Medical Society, the Chicago Physicians' Club, Chicago Medical, Chicago Gynecological and Scandinavian Medical Societies. At the time of his death he was president of the Chicago Medical Society, the largest city medical organization in the world.

One of the most remarkable features of Dr. Fenger's professional-social life was the ban-

quet extended to him by the members of the profession of America on November 3, 1900, at the Auditorium hotel in Chicago, in commemoration of the sixtieth anniversary of his birth. Over 500 physicians, representing all parts of the country, assembled to do him honor, and testify to the esteem in which he was held both as a surgeon and a man. It was a most eloquent tribute to his character. Little did those present think then that so soon would this brilliant and lovable man cease to be of their active number.

#### Dr. Albert C. Corr.

Again are we called upon to chronicle the death of an ex-president of the Illinois State Medical Society, in the person of Dr. A. C. Corr, of Carlinville, who departed this life on April 2, of the present year after a somewhat prolonged period of broken health.

Probably no member of the society was better known amongst its members than Dr. Corr. An almost constant attendant on its meetings for more than thirty years, his genial, kindly disposition made memory and friendships all the more tenacious. His social instincts and love of organization and its fruits made him a faithful and trusted worker in all the society relations to which he was assigned. His interest and readiness in debate made him a constant factor in the development of ideas, and familiarized his associates with his personality to a degree perhaps unequalled by any other member.

From various sources furnished by his devoted wife and others, we have been able to glean the following succinct facts relative to the life of this representative Illinois medical man:

Dr. Albert Campbell Corr was born in Macoupin Co., Ill., February 10th, 1840, his parents, Rev. and Mrs. Thomas Corr representing old pioneer stock from Virginia and Kentucky. His early education was secured in a typical log school-house of his native county. When not in school he assisted on the farm. Before completing arrangements for a higher education the civil war broke out and his older brother enlisted, throwing the care of the farm upon his young shoulders. However, in 1863 he entered Blackburn University, and was a student for one year, when,

his country's needs becoming more pressing, in May, 1864, he himself enlisted for service in Co. F, 133d Illinois Inf., and served four months. At the close of the war he resumed his studies, graduating from Blackburn University, and subsequently securing his degree of M. D. from the Chicago Medical College March 4th, 1868; the first physician from his county to take so extended a course. He

closely identified with his subsequent technical work. To the desire of the doctor that his wife be thus closely in touch with his work was due the fact of her taking up the study of medicine.

Aside from the routine of practice and writing, Dr. Corr occupied many official positions. In 1886 he relinquished the practice of general medicine and devoted his time



Dr. Albert C. Corr.

practiced in Chesterfield seven years, and afterward in Carlinville and East St. Louis. He assisted in organizing, and was a charter member of the Macoupin County Medical Society, in 1873. Of this he was for a long time secretary and subsequently president. He contributed to that society its decennial history. During that period he had never missed a meeting, and contributed more papers than any other member.

April 20th, 1865, Dr. Corr was married to Miss Lucinda Hall, who has been his professional associate, and consequently most

exclusively to diseases of the eye, ear and throat. In 1896 he was elected to the presidency of his State Society, to which he was the first delegate from Macoupin county, and its first treasurer. He was appointed by Gov. Altgeld to represent the profession of the state at the Pan American Medical Congress, Washington; was appointed by Gov. Tanner a member of the State Board of Health, and was for a time its president. He was a member of the American Medical Association, and of its Ophthalmic section. He was likewise a very active member of the



Southern Illinois Medical Association, whose interests he did much to harmonize, and was also made an honorary member of the North Central Association. He was for many years Expert Examiner in eye and ear disorders for the Pension Bureau, and surgeon-oculist to Henrietta Hospital of East St. Louis, as well as for several railroad corporations. He was, too, of an inventive turn of mind, having devised several instruments of value. His "lachrymal canal irrigator" is a simple and useful device. Also his "Schematic Eye," used in demonstration, and a "perfectly adjustable, self-retaining nasal speculum."

Dr. Corr, true to his social instincts, was a member of several fraternal organizations. Amongst these was the G. A. R., of the local Post, of which he was made commander. He was an apprentice in the Masonic order, and a Modern Woodman.

In respect to his religious tenets, Dr. Corr was long a member of the Methodist church, from which at his home the unusually large funeral cortege proceeded on the day of his burial.

In politics Dr. Corr was in all his active life a republican.

The occasion of Dr. Corr's death was a general breaking down of the nervous system, following many years of laborious professional work and under the strain of an asthmatic predisposition and digestive disorder. For only a couple of weeks would he permit himself to be confined to bed, and then, patient and uncomplaining, he sank to rest.

Dr. Corr's domestic life was exceptionally pleasant and his home a place of social resort, testified to by his neighbors as one of welcome to the cultured and refined of the neighborhood. In fact it was from such local surroundings that there was reflected in his State Society fellowship the noble character, loving disposition and devotion of Dr. Corr.

At a memorial meeting of the Macoupin County Medical Society on April 4th, 1902, resolutions were passed which have been already printed in the Journal.

It may be said in conclusion of this epitomic history of the life and work of Dr.

Corr, that he contributed much to professional literature both in and out of the several organizations with which he was connected. The following is a partial list of the subjects of his pen: "State Medicine and Sanitation" (1900). "Anomalies in Ophthalmic Practice" (1895). "Medical Aspect of Crime—a Strong Plea for Moral Training" (1896). "Little Things in Ophthalmology; three pamphlets, used in his Post-Graduate Teaching" (1891). "Vision; its Physical Defects and Mode of Correction; for teachers" (1890). "Trachoma of the Conjunctiva, not a disease of its own kind" (1895). "A case of error of Refraction Complicated with Esophoria, producing persistent Asthenopia" (1890). "Relations of Ophthalmology and Otology in General Medicine" (1901). "Minor Diseases of Nose and Throat that hinder Voice Culture; three papers" (1901). "Choroiditis and Choroido-Retinitis in Young Persons" (1896). "Specialisms in Medicine; the Relations of the Specialist and General Practitioner" (1899). "Advance in Ophthalmology and Otology." (1899). "A Resume of Ophthalmology" (1900). "Minute and Foreign Bodies Superficially Wounding the Eye" (1901). "High Myopia; Operations For" (1898). "Symptomatic Relations of the Eye in Derangement of the Nervous System" (1898). "The Relations of Catarrhal Conditions of Nose and Nasal Ducts and Errors of Refraction to Corneal Conjunctival Diseases. Question of Priority Incidentally Involved" (1898). "Influence of Nasal Diseases Perpetuating Diseases of the Eye. Illustrated" (1899). "Cyclitis" (1899). "The Necessity of Some Objective Method of Determining Refraction" (1902).

#### Dr. Cephas Park.

Dr. Cephas Park, the oldest physician of Henderson county, died in the city of Oquawka, September 23, 1901, at the age of 82 years. He was born in Wells, Vermont, November 8, 1819. His father, John Park, (of English descent) a veteran of the war of 1812, and his mother Sophia (Broughton) Park, were natives of Vermont, emigrating to Essex county, N. Y., and subsequently to Trumbull county, Ohio, where the son Cep-

has spent the earlier years of his life on a farm. Up to the age of nineteen he attended the district school, and then attended the high school at Warren, Ohio, for about two years. In 1845 he began the study of medicine with Dr. E. Blachley, of Niles, and subsequently with Dr. T. B. Wood, of Warren, Ohio. During the winter of 1844-5 he attended the course of lectures in Cleveland Medical College and received therefrom rec-



Dr. Cephas Park.

ommendation of efficiency as a practitioner. For a short time he was in Rockport, Ind., but in April, 1850, came to Oquawka, Ill. Not being desirous of practicing without a degree, and being limited in means, he for a short time conducted a small drug store, and in 1854 again attended the Cleveland College, from which he graduated. Dr. Park then returned to Oquawka, disposed of his drug business, and devoted his time to the practice of medicine and surgery, securing in a short time a large and lucrative clientele.

During his professional life Dr. Park was at various times associated in work with Dr. Snelling, Dr. C. W. Milliken, Dr. J. S.

Postlewait, and Dr. E. M. Hanson, retiring in favor of the last mentioned in 1897.

In 1836 Dr. Park was united in marriage with Miss Minerva Patterson, of Saybrook, Ohio, who departed this life December 29, 1887, the mother of six children, only one of whom (Miss Ida Park, of Oquawka) survives to mourn the loss of her parents.

Dr. Cephas Park was a self-made man, in the best sense of that term. He was one of the best known physicians in Western Illinois, and, as stated in a local paper, was beloved by his patrons unto the fourth generation, his long life affording opportunity for an abundant display of the knowledge, tact and kindness with which he was endowed.

Dr. Park was a man of extensive reading, and thoroughly posted in the literature of his profession and of affairs in general. He was esteemed for his honest and candid nature, his true friendship and his charity. He was honest and sincere in his convictions, and possessed the courage to express them. His influence was always for the upbuilding of the moral forces of the community—for temperance and justice. A man of cultured tastes and habits, Dr. Park was a typical gentleman of the old school. He was not a church member, but a constant attendant at the Presbyterian place of worship, toward whose financial interests he continued to contribute even after the heavy hand of chronic and disabling illness was laid upon him.

Dr. Park was a member always favorable to the organization of the profession for the needs of itself and the public, and was for a quarter of a century or more connected with his local and State Medical Societies.

Politically Dr. Park was a democrat, but finally voted for McKinley and with the republican party on the money question.

Chronic Bright's disease, with which he had been for a number of years afflicted, was the immediate cause of Dr. Park's death, although age had been making constant inroads on a once vigorous constitution. With his passing goes one of the pioneers of our western profession, weighted with love and respect.

# The Illinois Medical Journal.

The Official Organ of the State Medical Society.

EDITOR—George N. Kreider, A. M., M. D., Springfield.

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All communications should be addressed to the Editor, 522 Capitol Ave., Springfield, Illinois.

The Society does not assume responsibility for any statements or opinions published in the JOURNAL.

The JOURNAL is published monthly. The subscription price is \$3.00 per annum in advance. The JOURNAL is furnished free to the members of the Society.

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NOVEMBER 1902.

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## LOCAL SOCIETIES AND THE NEW LAW.

Thanks to the active work of the legislative committee a number of local societies have already considered the memoranda for a proposed bill for the regulation of the practice of medicine. In every instance, thus far reported the plan of the committee has met with hearty support and in addition several societies have pledged funds from their treasuries to assist in defraying the necessary expenses of a campaign. A

number of candidates for the legislature have already pledged their support to any reasonable bill brought up by the representatives of the State Society.

The Legislative Committee has just issued a personal letter to each member of every local society in the State, explaining the probable scope of the work during the coming session of the Legislature, and asking for the financial, as well as the moral, support of each physician. It is to be



hoped that every physician will feel enough personal interest to grant such support. The Chairman of the Legislative Committee, Carl E. Black, of Jacksonville, wishes us to say that where a county society makes a subscription out of its treasury, it is not expected that the individual members will send donations, but that each member of such society will be given due credit. This we think is a very good way for donations to be made. Montgomery and Sangamon counties have made donations at the rate of 50 cents for each member. If the candidate from your district has not already been pledged in favor of a better law speak to him at once.

#### **TALMA'S OPERATION FOR THE RELIEF OF ASCITES.**

There is a considerable responsibility involved in the introduction of novel operations by surgeons of eminence. This is apparent when it is remembered how certain procedures have suddenly acquired a widespread usage; the eagerness displayed by operators of lesser renown in imitating their colleagues of great distinction and the extent are occasionally elaborated without warrant.

The warning voice of some conservative leader has often brought about rather abrupt discontinuance of operations that were being vaunted and in some of these occurrences, so easily remembered, the abandonment of needless operations has only taken place after considerable sacrifice.

In a measure, these lamentable incidents are necessary attendants of progress; time is required to observe results, for data to accumulate and judgment to mature. On the other hand in some instances premature announcement has contributed to the general adoption of surgical measures of unproven efficacy and it would appear that the more general employment of animal experimentation might have averted criticism.

The operation devised independently by Talma of Utrecht and Morrison and Drummond in England for the relief of ascites, principally as it results from cirrhosis of the liver, is at present passing through that stage during which it is being advocated by some and derided by others.

In providing an outlet for the blood of the portal circulation, various methods have been employed such as stitching the omentum to the parietal peritoneum or to pockets made between the peritoneum and the muscles of the abdominal wall; in some cases the serous covering of the liver has been denuded of its protective endothelium. The aim has been to stimulate the proliferation of the blood vessels so that new channels will form and anastomose with vessels of the systemic circulation.

When Packard and LeConte<sup>1</sup>, reported 2 cases, they were able to collect from the literature 20 others. From an examination of the records, they were led to conclude that the operation was advisable in cases of "pure portal cirrhosis" in which medical treatment including paracentesis had been unsuccessful. With 2 cases of his own Harris<sup>2</sup> was able a year later, to bring the total number of reported cases up to 46. His conclusion, in some respects, is quite opposed to that mentioned above, for he found that the ascites although favorably influenced by the operation in a few cases was not benefited as a rule nor was the usual course of the disease modified. Although both articles cited, favor the limitation of the operation to cases of true alcoholic cirrhosis Bunge<sup>3</sup> has recommended it for the ascites of cardiac cirrhosis and cases of chronic peritonitis

(1) F. A. Packard and R. G. LeConte, the Surgical Treatment of Ascites due to Cirrhosis of the Liver, with Report of Two cases, *Am. Journ. of Med. Sc.*, 1901, CXXI, 251.

(2) M. L. Harris, The Surgical Treatment of Ascites due to Cirrhosis of the Liver, *Journ. Am. Med. Ass.*, 1902, XXXVIII, May 3.

(3) Verhandl. d. d. Gesellsch. f. Chir., 1902, XXX, I, 99

such as were discussed in these columns in our last number. F. Frank<sup>4</sup> has reported a case illustrating the danger of forming an angle in the colon by fastening the omentum to the upper part of the peritoneal cavity. A post-mortem examination in one of his cases showed that the symptoms diagnosed as stenosis of the pylorus had resulted from pressure on the duodenum by feces retained in the colon at the angle formed.

Surgeons have recognized the possible dangers from diverting the portal blood into the general circulation, but it can hardly be said that this phase of Talma's operation has met with the consideration due it. The products of digestion of proteid food compounds when introduced directly into the systemic circulation have a toxic effect and in animal experiments restriction to a non-nitrogenous diet has been necessary. A number of years ago Stolnikow, Pawlow and others were able to deflect the blood of the portal vein into the inferior cava by an Eck's fistula in a number of animals. Tansini<sup>5</sup> has recently repeated experiments of this nature. Of 10 dogs operated upon 7 survived the operation and when killed in a few months were to all appearances healthy; meat had been withheld from their food. Although his results are favorable to Talma's operation, it is desirable to have further observation. The subject is one that is full of promise for investigators and the readiness with which cirrhosis can be experimentally produced in animals suggests that possibly all the aspects of the disease as it occurs in man, together with the proposed remedial operations might be thus studied. As for Talma's operation it should be considered as still *sub judice*.

(4) *idem* p. 101.

(5) Tansini, *Centralbl. f. Chir.*, 1902, XXIX 937.

#### RETURN OF BIRTHS ACCORDING TO THE PROVISIONS OF THE NEW LAW.

Solely by the efforts of the State Medical Society a beneficent law providing for the accurate record of births and deaths and giving a small compensation for the same was placed on the statute books in 1901. It went into effect Jan. 1, 1902. The first

semi-annual report of returns was recently published by the State Board of Health. It shows that probably a fair proportion of the births had been made. In Chicago the Department of Health has kept a record of births for a number of years. The average number of births reported to the City Board of Health for the first six months of the past five years has been nearly 14,000. This shows that a large number of births remain unreported to the county clerk of Cook county since only 10,271 births were reported to him in the past six months. The county clerk appears to have no funds to pay for these reports and it is probably for this reason that a full report is not made to him.

Dr. C. S. Bacon, in a paper in this issue, estimates the number of births in Chicago to be between fifty-five and sixty thousand per annum. His figures are evidently made too high or else only about 40 per cent of the births are reported.

The total number of births in Illinois in the six months ending June 30 last was 37,898. Of this number 19,806 were males and 18,128 were females, with the sex of 174 not designated. In color 36,862 were white and 446 were colored. The number of births in cities and towns of a population of 5,000 or over was 5,641; in towns between 500 and 5,000 population, 7,388; in towns of less than 500 population and in the country, 10,417.

The nativity of fathers of children born was as follows: Illinois, 15,850; United States, 16,025; foreign, 9,736; not stated, 2,702. The nativity of mothers was: Illinois, 17,408; United States, 12,989; foreign, 8,686; not stated, 2,628. The number of twin births was 293; of triple births, 6; of still births, 1,013.

The total number of births of both sexes in each county was as follows:

Adams, 436; Alexander, 194; Bond, 164; Boone, 138; Brown, 111; Bureau, 371; Calhoun, 95; Carroll, 154; Cass, 150; Champaign, 462; Christian, 352; Clark, 267; Clay, 178; Clinton, 228; Coles, 427; Cook, 10,271; Crawford, 258; Cumberland, 189; DeKalb, 250; DeWitt, 204; Douglas, 174; DuPage, 211; Edgar, 308; Edwards, 139; Effingham, 175; Fayette, 327; Ford, 164; Franklin, 248; Fulton, 49; Gallatin, 205; Green, 214; Grundy, 187; Hamilton, 289; Hancock, 220; Hardin, 104; Henderson, 115; Henry, 399; Iroquois, 406; Jackson, 272; Jasper, 254; Jefferson, 270; Jersey, 102; Jo Davies, 138; Johnson, 230; Kane, 595; Kankakee, 347; Kendall, 82; Knox, 335; Lake, 267; La Salle, 815;

Lawrence, 241; Lee, 237; Livingston, 251; Logan, 259; Macon, 474; Macoupin, 427; Madison, 517; Marion, 339; Marshall, 156; Macon, 178; Massac, 148; McDonough, 215; McHenry, 222; McLean, 600; Menard, 120; Mercer, 173; Monroe, 93; Montgomery, 267; Morgan, 216; Moultrie, 176; Ogle, 206; Peoria, 714; Perry, 263; Piatt, 154; Pike, 283; Pope, 144; Pulaski, 143; Putnam, 46; Randolph, 305; Richland, 135; Rock Island, 417; Saline, 237; Sangamon, 649; Schuyler, 171; Scott, 92; Shelby, 289; Stark, 108; St. Clair, 555; Stevenson, 254; Tazewell, 319; Union, 290; Vermilion, 695; Wabash, 166; Warren, 176; Washington, 176; Wayne, 296; White, 302; Whitesides, 301; Will, 649; Williamson, 408; Winnebago, 407; Woodford, 230.

### THE EXPENSIVE DRAINAGE CANAL THE GREATEST SANITARY MISTAKE OF THE WORLD.

The Chicago drainage canal appears to be a splendid piece of engineering. It has given a good boating stage of water in the Illinois river at all seasons of the year. It has been of some sanitary benefit to the numerous cities situated on the banks of that river, but as a purifier of the water supply of Chicago, the purpose for which it was constructed, it is a conspicuous failure.

The only solution of the difficulty its friends propose is the extension of the system so as to cover an extensive district which is now pouring sewage into the lake. There is no certainty that even this will bring relief. Milwaukee, Waukegan and other cities on the west shore will still be sources of pollution. At a recent meeting of the Chicago Medical Society, Professor Hektoen expressed the opinion that the drainage canal is a stupendous blunder. His language in part was:

"After it has been shown that it is practically impossible to prevent the contamination of the city's water supply, the advisability of extending the sanitary district so as to include Evanston and South Chicago may well be doubted. Taxpayers have reason to be discouraged to know that, after they have expended over \$40,000,000, the drainage canal is a failure. The sanitary trustees may well consider some other method of purifying the water than digging more canals."

Language just a strong was used at a recent meeting of the Physicians' Club, a re-

port of which will be found in another column.

If we remember correctly medical men of Chicago of the widest sanitary knowledge protested against the construction of the canal and are now being vindicated. The proper expenditure of less than \$40,000,000 would have made Chicago the healthiest city in the world. Unfortunately as it now stands, a vast sum has been expended and there is no relief in sight. In almost every enterprise Chicago has been a wonderful success. In this most important matter she leads the world in making mistaken investments.

### PATRONAGE OF CHARLATANS DUE TO FAULTY EDUCATION.

Charles W. Eliot, president of Harvard University, in an address recently delivered, said:

Americans are curiously subject to medical delusions. They are the greatest consumers of patent medicines in the known world, and the most credulous patrons of all sorts of "medicine men" and women, and of novel healing arts. Is it not a just inference from the openness of the American mind to medical delusions that the common schools have not done what they ought to have done towards developing in the whole population the power to reason justly?

### State Items.

#### "Christian Science Is Applied Christianity."

At last we have been favored with a definition of Eddyism.

Carol Norton, member of the Christian Science board of lecturership of the First Church of Christ, Scientist, in Boston, Mass., spoke in the Second Church of Christ, Scientist, Chicago, recently and gave the revelation. Let no one be hereafter in doubt.

"Christianity, as Jesus lived, taught, and demonstrated it, and the scientific demonstration of Scientific Science made manifest in the healing of disease and the destruction of sin through the power of God, are one. Popular criticism of Christian Science assumes many



phases and pronounces almost countless judgments of its teaching and work.

"It is not infrequently asserted that Christian Science is but a passing fad, craze, or mental epidemic. The world of humanity is heart hungry, health hungry, and spiritually hungry. Christian Science satisfies this hunger with something practical.

"It is, therefore, not strange that an interpretation of the teachings of Christ that appeals to the masses should move with momentous force among the peoples of earth. A health epidemic is better than a disease epidemic, and moral, spiritual, and health contagion better than that of immorality, materiality, and disease.

"Therefore Christian Science is neither a fad, craze, nor a mortal mind epidemic."

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#### JUDGE ORDERED ACQUITTAL.

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**State Failed to Make Case Against Dr. Parker at Peoria.**

In the circuit court at Peoria a few weeks ago Judge Puterbaugh instructed the jury to bring in a verdict of not guilty in the case of J. W. Parker, on trial for murder, which they did without leaving their seats. This action was taken on a motion by the attorneys for the defense that the state had failed to prove their case.

Dr. Parker and R. G. Allen were indicted for causing the death of Miss Nella P. Cottingham of Tremont by means of a criminal operation. She was brought to this city by her parents the middle of February, a year ago, and died April 1 following at the Deaconess' hospital. The remains were shipped to Tremont, but brought back on the orders of the coroner. Dr. Allen has not yet been placed on trial.

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#### WARRANT FOR DR. CORNISH.

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**Specialist Accused of Obtaining Money by False Pretenses.**

Dr. James V. Cornish, Rush Medical College 1881, sometime a resident of Quincy, but recently "permanently" located in Springfield as a "specialist," has met the fate of all but the most "skillful" of this class and is apparently a fugitive from justice. The following extract from the Illinois State Journal gives the details:

Doctor Cornish, a specialist having an office at 204 South Sixth street, is wanted by Sheriff Woods on a warrant sworn out before Justice Brinkerhoff by George T. Willis, a car repairer

in the employ of the Illinois Central Railroad Company. In the complaint Willis alleges that Doctor Cornish secured money from him by false pretenses. The specific charge made by Willis is that Doctor Cornish guaranteed to cure him of rupture for \$10 and failed to do so.

Doctor Cornish was not in the city last night. Sheriff Woods is of the opinion that Cornish went from here to Quincy and a message was sent to the authorities there asking them to arrest Cornish. At 1 o'clock this morning the Quincy authorities had not located Cornish.

It is claimed that several other residents of Springfield have similar complaints against Cornish.

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The Illinois State Journal publishes the following item concerning the changes at the state institution at Lincoln:

#### **Dr. Taylor Assumes Duties.**

This morning Dr. John R. Barnett retired from the office of assistant superintendent of the State Asylum for Feeble-Minded Children in this city and Dr. Charles B. Taylor of Elkhart assumed the responsibilities of the position.

Doctor Taylor, who has been a practicing physician at Elkhart for years, is a staunch supporter of Governor Yates and a personal friend of Col. John D. G. Oglesby.

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#### **"Specialist" Held to Grand Jury.**

Dr. Lewis Pearce, a Chicago State street medical specialist, was held to the grand jury on the charge of obtaining money under false pretenses. "Lewis Pearce, alias Dr. Sweany," was the way the prisoner was described on the court docket. The complainant, J. McAlkin, alleges that he paid \$25 to the defendant and was given a prescription and told that only one druggist could compound it properly. At the drug store, McAlkin says, he was asked \$27 to have the prescription filled.

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#### **The Promoter of Herba Planta Accused.**

About April 1st, 1902, a stylish appearing individual appeared in Springfield and formed a company for the promotion of a whiskey cure called Herba Planta. A number of citizens were induced to buy stock and Central Illinois was flooded with advertisements entitled "No one need know." Whether any members of the profession swallowed the percentage bait we are not advised. The following extract from the Illinois State

Journal shows the last chapter of the enterprise:

H. W. Beatley, formerly manager of the Herba-Planta Company of this city, has been accused before the Sangamon county grand jury of embezzlement. Beatley's whereabouts at this time are not known here, but an effort will be made to locate him and return him to Springfield to answer the charge against him.

A few months ago Beatley's interest in the Herba-Planta Company, with offices on the east side of the square, were sold to Charles H. Dorwin. Up to that time Mr. Beatley acted as manager of the company and in that capacity was succeeded by Mr. Dorwin. Since Mr. Dorwin has taken charge of the business the books of the concern have been gone over carefully and this, it is claimed, has resulted in the discovery that Beatley was short in his accounts. It is charged that money which belonged to the company and was collected by Manager Beatley was not turned over to the treasurer, W. H. Butler.

It is likely also that a charge of obtaining money under false pretenses will be preferred against the former manager. False representations concerning the company's business it is claimed, were made to Mr. Dorwin when he purchased Beatley's one-fourth interest in the business.

### New Incorporations.

The Secretary of State at Springfield has licensed the following corporations:

The Cuterine Pharmacal company, Chicago; capital, \$2,500; manufacturing proprietary preparations; incorporators, E. A. Vosburgh, Walter R. Kirk and Milton B. Kirk.

The Franklin Drug company, Chicago; capital, \$2,500; dealing in and manufacturing drugs and toilet preparations; incorporators, Amzi W. Strong, Charles H. Rippley, and George H. Simpson.

Peoria Sanitary Milk company, Peoria; capital, \$10,000; to deal in milk; incorporators, W. H. Shugart, J. E. Elder and William Jack.

American Correspondence School for Nurses, Chicago; capital, \$50,000; educational purposes; incorporators, F. McCoy, L. W. Carl, and C. O. Gyrmire.

The Meleni Publishing and Medical Supply company, Chicago; capital, \$20,000; printing and publishing; incorporators, Alvah T. Martin, William T. Wright and Nettie Wiles.

American Association of Physio-Medical Physicians and Surgeons, Chicago; for the promotion of the science of medicine and surgery; incorporators, W. M. Haggard, L. F. Powers, and Charles M. Collins.

The Turnock Medical company, Chicago; capital, \$5,000; manufacturing proprietary medicines; incorporators, Ernst H. Stolz, Eugene Katz, and Charles J. Grady.

The Memorial Methodist Hospital, Mattoon; free treatment of afflicted humanity; incorpora-

tors, David M. McFall, James H. Clark, and James F. Hughes.

The Household Dispensary Company, Chicago; capital, \$2,500; dealing in wines, liquors and medicinal remedies; incorporators, Adolph S. Berg, Roy F. Fitts, and S. I. Yoder.

The Hygeia Vibratory Company, located at Augusta, Me., with a capital of \$500,000, is licensed to transact business in Illinois with a state capital of \$25,000.

The Ottomar Carliczek Company, Chicago; capital, \$50,000; manufacturing electro medical instruments and appliances; incorporators, Ottomar Carliczek, William Meyer, and A. N. Tagert.

### Local Societies.

#### Henderson County Medical Society.

##### Officers.

President, I. F. Harter.....Stronghurst  
Vice-President, J. C. Eads.....Oquawka  
Secretary, W. D. Henderson.....Biggsville

##### Members.

Bailey, J. A., Biggsville.  
\*Eads, C. J., Oquawka.  
Emerson, W. J., Carman.  
Graham, Ralph, Biggsville.  
Hanson, E. M., Oquawka.  
\*Harter, I. F., Stronghurst.  
Henderson, W. D., Biggsville.  
Marshall, H. L., Stronghurst.  
Meloan, J. F., Media.  
Noyes, B. F., Rozetta.  
Rankin, H. R., Media.  
Salter, E. W., Stronghurst.

#### The Scott County Medical Society.

Meets the Third Tuesday of each month.

##### Officers.

President, Jas. Miner.....Winchester  
Vice-President, G. M. Straight.....Winchester  
Secretary, J. P. Campbell.....Winchester  
Treasurer, G. C. Brengle.....Winchester

##### Members.

Brengle, G. C., Winchester.  
Campbell, J. P., Winchester.  
Day, L. R., Winchester.  
\*Day, W. C., Winchester.  
Dyer, C. H., Winchester.  
†\*Miner, James, Winchester.  
†\*Prather, J. E., Glasgow.  
Straight, G. M., Winchester.

On Wednesday afternoon, Sept. 17, 1902, a meeting was held at the court house by a number of local physicians for the purpose of discussing the propriety of organizing a county medical society.

There were present also from Jacksonville, Carl E. Black, Frank P. Norbury, A. L. Adams, T. J. Pitner. Carl Black addressed the meeting outlining the purposes and benefits to be derived from such an organization. After which a motion was made and carried that they proceed to organize such a society, same to be known as Scott County Medical Society.

A constitution and by-laws were prepared

and presented to the Society which, after discussion and amendment, were adopted. The following officers were elected: President, Jas. Miner, Winchester; Vice-President, G. M. Straight, Winchester; Secretary, J. P. Campbell, Winchester; Treasurer, G. C. Brengle, Winchester.

A committee on program and scientific work was appointed, consisting of J. P. Campbell, C. H. Dyer, J. E. Prather, G. C. Brengle, G. M. Straight and L. R. Day were appointed a committee on public health and legislation.

W. C. Day was appointed essayist for next regular meeting to be held at the court house Oct. 21st, at 1 o'clock P. M.

The Carroll County Medical Society met in Dr. Metcalf's office in Mt. Carroll, Sept. 16. The following officers were elected: President, J. Haller; Vice-President, F. H. Snow; Secretary and Treasurer, H. S. Metcalf.

In reply to the question whether physicians who are not graduates of regular medical schools should be admitted to membership it was decided "that no school of graduation shall be a bar to membership. The only condition shall be that the applicant if graduate of an irregular school must declare that he will not practice any exclusive system of medicine."

A county fee bill will be discussed at the next meeting.

H. S. Metcalf,  
Official Reporter.

The Bond County Medical Society met in its quarterly session on Thursday, Oct. 2d, at 1 P. M. in the court house with J. A. Warren, vice-president in the chair. Motion was made and carried that a committee of three be appointed by the president and that the president be one of said committee to look after itinerant doctors that were practicing illegally in the county, he appointed W. T. Easley and B. F. Coop. C. S. See of Pleasant Mound made application and upon investigation was found to be worthy and was admitted to membership in the Society.

G. C. Baker of Woburn read a paper on the use and abuse of the obstetric forceps, which was a very able paper and was discussed by Drs. Easley and Coop.

Wm. T. Easley, Official Reporter.

The McLean County Medical Society held its meeting October second. The subject of *Pyorrhoea Alveolaris* was presented by F. H. McIntosh, D. D. S. with discussion led by B. M. Vandervoort, D. D. S. and G. D. Sitherwood, D. D. S. There were a good number present, both dentists and physicians and much interest was manifested in the subject.

The names of Dr. Golding of Arrowsmith, and Drs. R. A. Noble and J. I. Hainline of Bloomington were proposed for membership. O. M. Rhodes was voted a member. The memoranda on the proposed medical legislation were favorably considered and the committee on laws, consisting of J. B. Taylor, F. C. Vandervoort and A. L. Fox, were instructed to meet candidates for legislature and obtain their views in the matter.

E. S. Reedy, Official Reporter.

The Military Tract Medical Association held a very interesting and instructive annual meeting, at Monmouth. The attendance and interest were good and an exceptionally good program was given. The arrangements for the meeting and social functions were most thoroughly arranged by the physicians of Monmouth. A fine banquet was served following an informal reception at Dr. Sherricks. Place of next meeting Peoria.

A resolution offered by President Coleman deploring the action of the state board in requiring Dr. Lorenz of Vienna to be examined for a license created a warm discussion and was finally voted down.

The following officers were elected: President, J. E. Coleman, Canton, Ill.; First Vice-President, H. C. Hopper, Galesburg, Ill.; Second Vice-President, W. S. Holliday, Monmouth, Ill.; Secretary and Treasurer, C. B. Horrell, Galesburg, Ill.

The sum of twenty-five dollars was voted to the legislative committee of the Illinois State Medical Society.

C. B. Horrell, Official Reporter.

The Vermilion County Medical Society met Monday evening, October 13th, in the city hall after a three months vacation to take up the winters work.

The board of censors reported favorably on the name of W. O. Lottman of Pilot followed by his election to membership.

The paper of the evening was on Appendicitis by W. A. Cochran which showed a thorough knowledge of the subject the discussion was entered into with interest by nearly everyone present and this will be considered one of our most valuable meetings.

A motion to recommend the proposed new medical bill to the Legislative Committee was carried unanimously; also a motion that the president appoint a committee of three to give the Legislative Committee all assistance possible from this locality.

W. A. Cochran was appointed chairman of this committee, the other two to be appointed at the president's convenience.

There being no further business the Society adjourned to the November meeting.

E. E. Clark, Official Reporter.

The Whiteside County Medical Society.

Our Society being only recently organized the time has been in the greater part taken up perfecting our organization. We have had three meetings the last one was held the 9th, inst. in Morrison at which time a paper was read on Typhoid Fever by Dr. Parker of Sterling, the paper was followed by a free and general discussion by all present. The subject was one of special interest on account of there being several cases over the county.

The next meeting will be held in Sterling, November 12th.

To the list of members that you have the names of S. B. Dimond, Albany, and R. A. Mathew, Morrison, may be added.

Finis Purdue,  
Official Reporter.



The Champaign County Medical Society met in the parlors of the Beardsley Hotel at 2 P. M., Oct. 16, 1902.

Meeting was called to order by the president of the Society. Members present were: Drs. Johnson, Bartholow, Mandeville, Cushing, Matheney, S. W. Shurtz, R. D. Shurtz, Mason, Kinchloe, Newcomb, Burres, White and Wall. The subject of affiliation of local with state medical society was up for discussion and was laid over until our next meeting. A number of the members objected to being made members of State Society and compelled to pay the dues.

The memoranda of proposed medical practice act bill was endorsed by the Society with the exception of section 12. The members objected to this section and protested against its passage.

J. D. Mandeville read a paper on the inter-communicability of tuberculosis which was discussed by Drs. Bartholow, Johnson, White and Wall.

J. E. Lowery of Foosland applied for membership in Society.

Society adjourned to meet in December.

A. S. Wall, Official Reporter.

The DeWitt County Medical Society convened in the county court room October 14, 1902, at 1 o'clock P. M.

Minutes of the previous meeting were read and approved.

J. C. Myers reported a very interesting case of pelvic peritonitis resulting in an abscess which opened into the rectum.

W. H. Kirby reported a case of carcinoma of liver which terminated fatally in about seven months.

Dr. McMackin reported a case of uterine trouble complicated with rectocele, asking for suggestions in treatment of same.

Dr. Dodge of Iona was a visitor and on motion of society was requested to participate in the meeting. He reported an interesting case of chronic hysteria.

Dr. Tyler spoke of the inefficiency of our state medical practice act to protect the unsuspecting sick from the impositions of quacks and rascals, and recommended the proposed bill of the State Medical Society, but before any special action could be taken time for adjournment arrived.

John H. Tyler, Official Reporter.

The Pike County Medical Society met at the office of H. T. Duffield in Pittsfield, October 23, 1902.

President H. T. Duffield presided.

Members present: H. T. Duffield, G. W. McComas, C. E. Beavers, L. J. Harvey, F. M. Crane, P. W. Brown, W. E. Shastid and R. H. Main. Minutes of April meeting read and approved. No meeting was held in July.

The following physicians were elected to membership in the society:

W. T. Thurman, Detroit; J. S. Thomas, Pleasant Hill; R. J. McConnell, Baylis; W. W. Gay, Rockport.

The bill proposed by the Legislative Committee of the State Society "for the regulation of the practice of medicine and establishing a board of medical examiners, etc.," was endorsed

by this society.

A motion was passed by this society to amend the constitution so as to correspond with the proposition of the State Society making the local societies a part of the State organization. The matter will be finally acted upon at our next regular meeting.

W. E. Shastid spoke on "Perforations of the Membrana Tympani."

G. W. McComas read a paper on "Surgical Hints."

C. E. Beavers presented specimens and photographs of a case of Congenital Angioma, involving almost the entire posterior of the body. He also presented a cystic ovary removed from a girl 17 years of age.

R. H. Main,

Official Reporter.

The Pulaski County Medical Society met in regular session Tuesday, October 7, 1902, with the following physicians present:

President M. L. Winstead, J. F. Haragan, J. B. Mathis, Sr., B. A. Royal, W. C. Rife, Hall Whiteaker, W. J. Whiteaker, B. F. Brown, A. W. Tarr, Dr. Fulkerson, and C. B. Powell.

After the regular business of the society was transacted, the scientific part of the program was taken up.

The first paper was "Treatment of Malaria," by J. F. Haragan of Mound City. This was a valuable paper owing to the fact that we have malaria to contend with in all diseases of this locality, consequently it was very thoroughly discussed by all the doctors present.

The author thought it wise to begin early with good doses of calomel followed by saline cathartic and this to be repeated as often and as long as symptoms required.

He advised gelsemium and aconite to control fever leaving off the coal tar products on account of their depressing effect on the heart.

B. A. Royal read a paper on the treatment of abortion, in which he placed much stress on tamponing to control hemorrhage and to assist in removing a retained placenta, as after the tampon had remained for seven or eight hours, when removed the placenta usually comes away with the tampon, or the os is sufficiently dilated that there is but little trouble in removing it.

His special point was to remove placenta as soon as possible for by doing so, all hemorrhage would cease and the dread of septic infection would be removed, and this he nearly always does by tamponing and with his finger, scarcely ever having an occasion to use the curet.

The paper was ably discussed by all the doctors present and some very valuable points were brought out.

The next was a paper on "The Treatment of Dropsy," by J. B. Mathis, Sr., but owing to lack of time the doctor's paper was not complete, but he gave the causes, symptoms and diagnosis which was very complete and of great value to the society.

This was one of the most enthusiastic meetings that the society has had and much information was gained from the papers and their discussion.

After the scientific part of the program had been disposed of the society adjourned to meet again the first Tuesday in January, 1903.

Charles J. Boswell,

Official Reporter.

The Kendall County Medical Society held its annual meeting in the parlors of the Hotel Nading, Yorkville, Oct. 7th, members present Drs. Freeman, Hanna, Churchill, Moore, Frazier, Riggs, Hanawait and Kinnett.

President Freeman in the chair; Secretary McClelland absent, Dr. Kinnett acted as secretary. Minutes of last meeting were read, application of B. E. LaDue of Plano for membership was read and referred to board of censors upon their approval the doctor was elected by ballot. Communication from chairman Dr. Black of the legislative committee requesting this society to endorse memoranda on medical legislation was read and placed on table for reason that the secretary, who had some correspondence with Dr. Black was absent and society was undecided what to do. Dr. Churchill of Oswego presented a very well prepared paper on **ectopic gestation**, paper received a full discussion other papers were ready for presentation but this being the annual meeting for the election of officers it was voted to defer them and the Society proceeded to elect officers, and the result is as follows:

President, Wm. Hanna; Vice-President, F. R. Frazier; Secretary-Treasurer, R. A. McClelland. Though there were but few members in attendance all felt well pleased, and Society voted to change the time of meeting to an evening one, after which would follow a social time with refreshments.

R. A. McClelland,

Official Reporter.

The Rock Island County Medical Association met October 17th at Hotel Windsor. Together with a large gathering of its own members were many guests from the other county organization and from Davenport. M. L. Harris of Chicago, the president of the Illinois State Medical Society was the special guest of honor and was the messenger that brought good news of peace. It is owing to his efforts that the two rival medical societies are at last to be amalgamated. At a preliminary meeting of the officers of both societies the following resolution was passed:

Resolved, That the members of both societies come together and form a new society and elect officers under the name of the Rock Island County Medical Association, with the understanding that all members of both societies shall be charter members of the new Society, and that an invitation be extended to all regular practitioners of the county to become members.

After a banquet the following papers were read and discussed: **Empyema of pleura** by M. L. Harris, of Chicago, and **Observations and deductions from surgical operations on biliary passages in twenty-four cases** by Dr. Hageboeck of Davenport. The masterly treatise of Dr. Harris left but little more to be said. He drew for his data from personal experience and laid particular stress on early diagnosis and

surgical interference with thorough drainage. He received from the association a vote of thanks for his efforts in behalf of peace and for his excellent paper. His paper was freely discussed but so strong and logical was he in his treatment of empyema in all its aspects that no exception to any of his paper was taken by any present.

Dr. Hageboeck, too, drew from personal experience in his paper. The prognosis of laparotomy for gall stones with Dr. Hageboeck as surgeon is good as he only had one death in twenty-four operations.

His classification of different forms of biliary obstruction into eight classes was scientific and clear and was in itself a lesson worth knowing and an evidence of the great ability of the operator.

A vote of thanks was given by the association of Dr. Hageboeck.

Next Friday, October 24th, both societies will meet and elect officers and formulate a constitution.

The association adjourned sine die.

A. D. West, Official Reporter.

The Macoupin County Medical Society met in the Masonic reading room, Carlinville, at 10:30 A. M.

President Gobble of Greenfield called the society to order and the following members answered to the roll call: L. H. Corr, Carlinville; W. B. Dalton, Scottville; C. J. C. Fisher, Carlinville; Ben Hudson, Palmyra; A. G. Kinkad, Greenfield; J. P. Matthews, Carlinville; J. Palmer Matthews, Carlinville; H. W. Gobble, Greenfield; J. P. Denby, Carlinville; G. E. Hill, Girard; M. J. Donohue, Plainview; J. M. Barcus, Carlinville.

Secretary's report read and approved.

Treasurer's report was adopted showing a balance on hand of \$2.55.

The board of censors reported on the applications of L. M. Nifong, Modesta; George A. Wash, Palmyra, and S. A. Huffman, of Chesterfield. The secretary, on motion, cast the ballot of the society for the gentlemen and the president declared them elected members of the society.

A communication was read from the Western Illinois District Society, Dr. Chapin, White Hall, secretary, asking that we affiliate with them.

On motion we appointed delegates and affiliated with the above named society.

A committee was appointed by the chair to draw up resolutions of respect to the memory of our deceased brother, C. T. Dripps, of Staunton, to report at next meeting. Committee, J. P. and J. Palmer Matthews and Dr. Collins.

A letter was read and telephone message received from J. A. Egan, secretary State Board of Health, expressing regrets that he could not be with us to address us on State Medicine and Sanitation.

Reports of cases: J. P. Matthews reported a case of **incipient tuberculosis** in young girl. Blood, 70 per cent haemoglobin by tonics raised to 100 per cent. R. H. Goat lymph used subcutaneously; also anti-tubercle serum. A general supportive treatment with creosote 30 drops a day has kept flesh on the patient and the



lung is just beginning to show objective symptoms of involvement in apex.

The microscope of 1-12 oil immersion demonstrated tubercle bacilli in sputum and a specimen slide was on exhibition.

At afternoon session J. P. Denby read a paper on **Haemoptysis**, which on motion was accepted as a contribution to the society.

Haemoptysis is a symptom, not a disease. But the coughing up of pure blood being the first objective sign of disease gives it importance.

It indicates active or passive congestion of bronchial mucous membrane, with possible degeneration of blood vessels.

Tuberculosis is the cause in 90 per cent of the cases.

Rupture of an aneurism into bronchi may be a cause.

Vicarious hemorrhage at time of menstruation is conceded to be a common cause.

Large hemorrhages are fortunately rare—of 1 or 2 pints—and result from rupture of vessel into tubercular cavity.

A gush of blood into mouth without premonitory symptoms is usual. Bright red; frothy and salty to the taste.

If hemorrhage is small symptoms are only those due to mental shock or restlessness and anxiety. In severe cases there is pallor, faintness and collapse with rapid pulse and subnormal temperature.

Necessary to exclude spurious haemoptysis viz from mouth, nose, pharynx and larynx.

Physical signs are negative.

Treatment: Recumbent position is imperative to relieve respiration and heart's action; to favor formation of thrombus.

Give morphine and atropine to quiet circulation, combined with bromides and aconite to relieve nervousness. Sucking pieces of ice relieve coughing. A saline laxative should be given. In organic heart disease causing passive congestion, digitalis and strychnine are indicated. In overfilling of right heart venesection is the quickest relief. In advanced tuberculosis strapping of chest is good. Normal salt solution is indicated after repeated attacks where patient is ex-sanguinated. Strychnine and warm applications should keep up bodily temperature and the patient should be watched three or four days after last return of hemorrhage.

In the discussion ligating the extremities was recommended for immediate relief, and veratrum and glonoin and nitrates were indicated to bleed patient into his own veins. So also arterial tonics or constrictors are contra-indicated, such as digitalis and ergot.

Dr. Barto sent a case of **Colle's Fracture**. Treated with long anterior inter osseous splint, well padded and extending to phalanges. The displacement was reduced with but slight provisional callous.

The secretary read a paper for Dr. Barto, who was absent, on **Impetigo Contagiosa**. Synopsis: Tilbury Fox gave the name Impetigo to a group of symptoms characteristic of a certain disease.

An eruption preceded by a febrile stage occurs in childhood and early adult life in the

form of isolated vesicles and vesico-pustules usually about the face and hands. The lesions are the size of a split pea, becoming covered with a straw colored crust adherent to a reddened base. Involution takes place before two weeks. The contents of the lesions are inoculable and auto-innoculable, spreading from one member of family to another. Subjective symptoms are mild with slight itching.

The course of Impetigo Contagiosa is simply infection with pus-cocci by picking the nose and scratching the head.

In Unna's differential diagnosis of Impetigo and eczema pustule stress is laid on the sero-purulent character of the latter with dissemination of the cocci through the lesion.

In impetigo the staphylococci are clustered and extra cellular relatively small and are well secured beneath the roof wall of the lesion. Dervevre reports a number of successful inoculations with contents of the vesico-pustule covering crusts and scrapings from the erosions underneath.

Diagnosis: Differentiate from eczema pustulosum. 1. Absence of infiltration of tissues. 2. Absence of intense itching. 3. Failure of lesion to form patches. 4. Isolation of lesions, distinctly pustular. 5. Persistent character of the pustules. 6. Evident termination of the disease with pustules being the initial stage of a distinct disease.

In Ecthyma the pustules are deep seated, while in Impetigo they are not, nor is there infiltration of base, but crust is superficial and lesions are numerous. In pustular Eczema the lesions are in patches, while in Impetigo they are isolated and numerous.

Treatment: Individual pustules should be opened with an aseptic comedo needle and the contents expressed and an ointment of ammoniated mercury and cold cream applied as an efficient germicide.

Discussion brought out that the characteristic scab of Impetigo is epithelial scales, with no infiltration, while the confluent scab of Eczema is leucocytes and epithelium infiltrated with pus-cocci.

Carl E. Black, who was to read a paper on **Concussion of the Spine**, telephoned he was unavoidably detained, but urged upon us to take some action in regard to the proposed bill for the regulation of the practice of medicine and establishing a board of medical examiners in the State of Illinois. A motion was unanimously carried—

Resolved, That the Macoupin County Medical Society does hereby endorse the action of the Legislative Committee of the Illinois State Medical Society and take this manner to personally recommend the bill of the Committee and in every way, financially if necessary, to enable them to pass the bill they recommend.

Before adjournment subscriptions for the aid of the Committee were responded to by all members present and \$11.00 sent to C. E. Black.

The committee on program reported Drs. Wash and Nifong to read papers at the next meeting to be held in Carlinville on April 28, 1903.

J. Palmer Matthews,  
Official Reporter.



The Montgomery County Medical Society met in annual session in the parlors of the Hillsboro Commercial Club in Hillsboro, Oct. 7, 1902, with president W. H. Cook in the chair. Members present: Cook, Haynes, Wilson, Whitten, Mayer, Fullerton, Kelly, Lockhart, Douglas, Snell, Leigg, Houser and Clotfelter.

Visiting physicians, Kreider, Canaday, Kimball, Seymour and Allen.

Minutes of last meeting read and approved. The program was announced by the president, and the following papers were read:

Notes from New York Polyclinic, C. H. Lockhart.

The technique of several operations as performed by the eastern surgeons was described; general discussion followed.

Diagnosis of nonstructural diseases of the stomach, G. A. Clotfelter.

Pathology and treatment of endometritis, G. N. Kreider.

This was an interesting and instructive paper, being illustrated by pathological specimens and microscopic sections.

Dr. Kreider also spoke on the subject of medical legislation after which the following resolution was presented and adopted.

Resolved by the Montgomery County Medical Society, that we heartily endorse the action of the legislative committee of the State Medical Society in securing a revision of the medical practice act, and will do all in our power to influence our legislators to secure the passage of the law, and we donate the sum of ten dollars to be used if necessary.

The history of medicine, M. W. Snell....

This was an interesting subject well presented, showing evidence of careful research on the part of the essayist.

The applications of Z. V. Kimball, R. N. Canaday and F. W. Barry being favorably reported by the board of censors, they were elected to membership in the society.

Officers were elected for the ensuing year as follows: President, W. A. Cook, Coffeen; Vice-President, F. C. Blackwelder, Litchfield; Secretary and Treasurer, G. A. Clotfelter, Hillsboro; board of censors, T. J. Whitten, M. L. Moyer, M. W. Snell.

There being no further business the Society adjourned to meet in Litchfield the first Tuesday in May.

G. A. Clotfelter,  
Official Reporter.

The Fulton County Medical Society held its fifth annual meeting in the parlors of the Churchill House, Canton, Ill., Oct. 7, 1902.

Called to order at 11 A. M. by President Stoops.

The following members were present: Wm. Plummer, Stoops, Blackstone, Harrison, Roberts, Ray, Sutton, Heise, Zeigler, Miller, Scholes, Regan, Chapin and Dixon.

Applications for membership from S. A. Oren of Lewistown and F. C. Robb of Farmington were balloted upon and both declared elected to membership in the Society. Dr. Sutton presented brief synopsis of the proposed medical legislation by the Legislative Committee of the Illinois State Medical Society and moved that the Society fully endorse the effort

and hereby pledge money and labor in its support.

The motion was carried unanimously.

The secretary was instructed to answer Dr. Black's letter relating to this proposed legislation and inform him as to our position on the question.

Adjourned for dinner.

A sumptuous dinner was served the members and their ladies to the number of twenty.

Two P. M. called to order and the president presented the annual address, which proved to be an exceedingly excellent review of modern medicine. Its compilation gave unmistakable evidence of laborious research, a fine appreciation of the good, was attentively listened to and ably delivered.

The president appointed Drs. Scholes, Robb and Reagan as committee to select meeting place for December meeting. They reported Farmington as their selection and recommended an afternoon session. Their report was adopted.

Treasurer's and Secretary's reports were read and accepted.

Treasurer's report showed a balance on hand of \$4.80.

The following bills were presented, allowed and ordered paid.

Thomas & Snivley, printing January and June programs, \$3.00.

D. S. Ray, postage, \$1.80.

Churchill House, 20 dinners, \$10.00.

The following officers were unanimously elected:

Dr. Roberts of Farmington, president.

Dr. Scholes of Canton, First Vice-President.

Dr. Plummer of Farmington as Second Vice-President.

Dr. Ray of Cuba, secretary.

Dr. Harrison of Bryant, treasurer.

Dr. Miller of Canton, Necrologist.

Dr. Sutton of Canton, membership committee.

Dr. Scholes of Canton, board of censors.

Drs. Robb and Roberts presented two interesting cases of **craivial fracture** and Dr. Stoops an **ulcerated stomach** and called attention to the fact that pain and distress occasioned by it had been relieved both by pressure and food.

Extensive adhesions with the transverse colon had occurred and perforation.

Dr. Oren, membership fee.....	\$1 00
Dr. Robb, membership fee.....	1 00
Dr. Oren, dues.....	1 00
Dr. Robb, dues.....	1 00
Dr. Harrison, dues.....	1 00
Dr. Zeigler, dues.....	1 00
Dr. Blackstone, dues.....	1 00
Dr. Heise, dues.....	1 00
Dr. Sutton, dues.....	1 00
Dr. Miller, dues.....	2 00
Dr. Stoops, dues.....	1 00
Dr. Wm. Plummer, dues.....	1 00
Dr. T. R. Plummer, dues.....	1 00
Dr. Roberts, dues.....	1 00
Dr. Scholes, dues.....	1 00
Dr. Chapin, dues.....	1 00
Dr. Regan, dues.....	1 00
Dr. Ray, dues.....	1 00
	\$19 00

D. S. Ray, Official Reporter.

The Rock Island County Medical Society met in regular session at the Harper House, Rock Island, Tuesday evening, Sept. 23, 1902, and was specially fortunate in having as the guest of the evening Harold Moyer of Chicago. In the absence of the president the meeting was called to order by the Vice-President, L. D. Dunn of Moline. Owing to the absence of the secretary, Martha Anderson of Moline was chosen secretary for the evening.

Those present at the meeting were Harold Moyer of Chicago, C. C. Carter, Eyster, Hollowbush, Ludwig, Sala, First, Ostrom and Comegys of Rock Island, Dunn and Anderson of Moline, Craig of Aledo and Block of Port Byron.

The reading of the minutes of the previous meeting was necessarily dispensed with. Dr. Eyster was appointed teller and the following names for membership were voted upon individually by ballot, Henry S. Bennett, T. J. Lamping and H. D. Browning all of Moline. The vote in each case was unanimous.

The name of Emma Morgan was proposed for membership, recommended by Drs. Sala and First.

The first paper on the program, **Infantile Convulsions** by A. R. Beal, was omitted, the doctor being absent. Dr. Hollowbush made remarks on the subject of **Ectopic Gestation** and reported a case, the pregnancy taking place in the uterine end of the tube. The patient was operated upon and recovered. It was moved and seconded that Dr. Moyer be invited to take part in the discussion. The subject was discussed by Drs. Eyster, Carter, Ludwig and Sala all of whom reported a case. Dr. Hollowbush closed the discussion.

Dr. Eyster presented a paper on the **X-Ray treatment of Carcinoma of the Breast**, reporting a case under treatment. Dr. Moyer gave a very interesting talk on the history of Radiotherapy, literature on the subject, the use of the X-Ray in the treatment of Carcinoma Sarcoma, lupus, acne, and other pathological conditions, reporting cases he had seen under treatment and referring to Dr. Pusey's excellent work along that line. He also spoke of the **Becquerel Ray** and its identity with the X-Ray. The use of caustics, pastes, and the knife was touched upon. The discussion was further participated in by Drs. Ostrom, Carter, Dunn, Hollowbush, and others.

Dr. Carter requested that Dr. Moyer talk to the Society on the subject of **Personal Injuries—the difference between real and assumed injuries, hysterical conditions, etc.** Dr. Moyer readily responded and gave an exceedingly interesting and instructive talk on the subject which occupies so much of his attention.

It was moved and seconded that a vote of thanks be given Dr. Moyer for his very enjoyable talk. Dr. Moyer in turn thanked the Society for being allowed to speak.

The secretary was instructed to send the proceedings of the meeting to the Illinois State Medical Journal for publication. The meeting was then adjourned.

Martha Anderson, Sec. pro tem.

The Stephenson County Society of Physicians and Surgeons held a regular meeting at Freeport, Thursday, Oct. 9, 1902, president J.

F. Fair presiding. Minutes of previous meeting stood approved as read. C. A. Burwell and K. F. Snyder, of Freeport were elected to membership and J. N. Daly's name was proposed for membership which according to rules was referred to the board of censors until next regular meeting.

Communication from E. W. Weis with blank application was read and on motion the president and secretary were authorized to fill blank to comply with section 9, article 3, of Illinois State Medical Society by-laws and return same to State Society's secretary. Communication from C. E. Black (chairman of committee on legislation from State Society) was read and in harmony with same the following resolution was adopted.

Whereas: The physicians of Stephenson County are heartily in accord with the committee on legislation from the Illinois State Medical Society and their report of a proposed law for establishing a board of medical examiners in the State of Illinois and regulating medical education and medical practice, as unanimously adopted by the Illinois State Medical Society at their last meeting at Quincy, therefore be it

Resolved, That we the members of the Stephenson County Society of Physicians and Surgeons urge the representatives from this senatorial district to use their influence and co-operate with the committee from the Illinois State Medical Society in securing legislation to better the condition of our State laws pertaining to the practice of medicine, sanitation, etc. Be it further

Resolved, That a copy of these resolutions be furnished each of the representatives from this district and a copy sent to the Illinois State Medical Journal for publication.

It was regularly moved and carried that the secretary notify all the members of the Society of the action taken on Secretary Weis' communication and that he furnish copy of resolution to legislator and senator from this senatorial district.

J. H. Stealy read a carefully prepared paper on "**ununited fractures**" in which he set forth in an able manner causes and treatment.

M. J. Stees read a paper, entitled, "**therapeutic as the aim of research and its dependence for application upon diagnosis,**" in which she covered the subject in a thorough and interesting manner.

L. G. Voigt reported three surgical cases using photographs for illustration.

Both papers and reports were well received and discussed at considerable length by the various members.

There being no other business before the meeting, Society adjourned.

Robert J. Burns,  
Official Reporter.

The Southern Illinois Medical Association. Program of the 27th annual meeting of the Southern Illinois Medical Association to be held in Centralia, Ill., Nov. 6-7, 1902.

J. A. Helm, Metropolis, president; M. D. Empson, Hartford, vice-president; O. B. Ormsby,



Murphysboro, secretary; Chas. E. Riseling, Murphysboro, assistant secretary; A. T. Telford, Olney, treasurer.

Thursday, November 6.

Call to order by President J. A. Helm at 10 A. M.

Invocation by Rev. C. A. Beckett.

Roll call.

Address of welcome by C. N. Dunn, Centralia.

Response by J. T. McAnally, Carbondale.

Reading minutes of the last regular meeting.

Appointing Board of Censors by the President.

President's Memorial Address.

1. Has Medication a Place in the Therapy of Nervous Disease, D. S. Booth, St. Louis, Mo.

2. Enucleation of an Atrophic Eye, with Implantation of Glass Ball into the Orbital Cavity and Re-attachment of the Recti Muscles in their Original Position, J. E. Jennings, St. Louis.

Adjournment until 1:30 P. M.

1:35 P. M.—Call to order by president.

1. The Surgical Treatment of Hernia, Frank Boyd, Paducah, Ky.

2. A Clinical Report of Cases, A. E. Miller, Metropolis, Ill.

3. Circular insanity, Frank P. Norbury, Jacksonville.

4. Report on a case of Epilepsy, Prof. Geo. H. French, Carbondale.

5. Puerperal Fever with Report of a Case, J. H. Sams, McClure.

6. Pneumonia, Hy. G. Horstman, Vergennes.

7. Strabismus in Children, Jas. W. Dunn, Cairo.

Report of the Board of Censors.

Adjournment.

The usual entertainment will be tendered the visiting profession.

Friday, November 7, 1902.

Call to order by President Helm at 9 A. M.

1. Diseases of Children, J. Sloey, Lebanon.

2. Tuberculosis with Report of Cases, A. M. Lee, Menard.

3. A Perplexing Case of Intestinal Obstruction, W. F. Grinstead, Cairo.

4. The Practice of Medicine from a Financial Standpoint, A. C. Ragsdale, Metropolis.

5. Trachoma and How to Treat it, Geo. C. Adams, East St. Louis.

6. Malaria and Mosquitoes—Their Cause and Prevention, M. L. Winstead, Wetaug.

7. Enucleation of the Eye, its Indication, operation and subsequent treatment, D. Winton Dunn, DuQuoin.

8. The Prevention of Certain Urethral Troubles in Females, J. A. Hale, Alto Pass.

9. Medical Legislation, J. T. McAnally, Carbondale.

10. Acute Cystitis, J. H. Horgan, Mound City.

11. Selection, C. S. Bacon, Chicago.

Adjournment until 1:30 P. M.

1:30 P. M.—Call to order by the President.

### Typhoid Fever.

1. Etiology and Modes of Infection, Chas. E. Riseling, Murphysboro.

2. Early Signs and Diagnosis, C. W. Lillie, East St. Louis.

3. Treatment, B. F. Scaiefe, Sailor Springs.

4. Few remarks on Treatment, W. W. Essick, Murphysboro.

5. Anatomy in Relation to Diagnosis of Intra-Abdominal Lesions, J. L. Wiggins, East St. Louis.

The East St. Louis Medical Society met October 13th, at 8:30 P. M., J. W. Rendleman, President, in the chair. C. W. Lillie, Secretary pro tem; and McLean, Campbell, Hanson, Dwyer, H. D. Smith, Whitmer and Housh.

Minutes read and approved. Committee appointed at last meeting to report upon the proposed law for a medical examining board asked for further time which was granted.

Dr. Hanson read a report of an unusual case of obstruction of the bowels.

The paper elicited considerable discussion from which we abstract the following:

**Campbell**—I judge this was a case of fecal impaction with paralysis of bowel. If the impaction was perforated or tunneled, the bowels would still move. The impaction caused the paralysis. The result shows that the right thing was done. It was just what would have been done had the exact condition been known. In cases of obstruction the time to operate is before the extreme prostration. I recall a case of a young man in the city hospital who was prepared for operation, but at the last moment he refused. High enemata relieved this patient. The amount of water that can be injected gives an idea of the point of obstruction.

**Housh**—I have had two cases of fecal obstruction, both having umbilical hernia. Neither would submit to operation and both died. One of these was in a young person and the other in an old one. They might have died with operation. The tumor in these cases was as large as a baby's head. I saw a case operated upon by a St. Louis surgeon with recovery.

**Rendleman**—I had a case like this a year ago. A young man came to the office. I made a diagnosis of appendicitis and sent the patient to the hospital and operated, finding a perforated appendix which was excised. The wound was closed and the skin was apparently healed, but later opened and eleven days after entering the hospital there was discharged through the opening a handful of grape seeds and skins. According to his statements the grapes had been eaten three weeks previously. The tongue appeared dry and cracked.

**Whitmer**—I saw a case four years ago in the hospital with a history of intestinal obstruction of five days standing. Patient was moribund. Fenger operated but no obstruction could be found, although there had been no movement of the bowels for five days. The wound was closed and an opening made over the liver revealing gall stones, one of which was lodged in the common duct, for the removal of which a special instrument was devised, and it was later removed. The bowels moved after the operation, although no bile had yet entered the bowel.

**Lillie**—I saw this case with Dr. Hanson and found it extremely interesting. At the time I saw the patient, about 7:30 on Friday evening, she was in a critical condition. Pulse



rapid, respiration shallow and hurried, the abdomen greatly distended, and the nervous system quite excited. In addition to the treatment given by Dr. Hanson in his report turpentine stupes were applied to the abdomen. Regarding the cause of the obstruction we may assume that it was due to a combination of causes. The condition of chronic constipation results in a decomposition of foods in the bowel producing toxins, and these acting upon the nerves deaden the activities of the bowel muscles so that a paralysis may result from this combined with the distention due to the accumulation of gases, all taken together inducing a still greater degree of torpor. Another factor in this case may be the weight of the accumulated bowel contents pressing upon the nerves supplied to the bowel. While this patient was upon her feet for a large portion of her time, but little effect was observed, but when, after her confinement, she assumed recumbent posture the continuous pressure overcame the vital energy of the nerves and a paralysis resulted. For this condition the large doses of strychnia hypodermatically is the remedy.

**Hanson—Closing.** I found by examination in this case that the colon was small and rigid, and the mesentery short. Bowel admitted of but little movement. This might have been the cause of the constipation. A question with me is why did the water not pass the splenic flexure? Had it not been for the paralysis I would have operated. I had the full consent of the patient.

J. W. B. Dwyer reported a case of **stab wound of abdomen**, which appeared slight at first, but which resulted in peritonitis and death.

W. H. McLean reported a case of **stab wound of liver** upon which he operated, and patient recovered. Thinks that in all cases of doubt as to penetration of cavity exploratory incision should be made.

C. W. Lillie,  
Official Reporter.

The Sangamon County Medical Society met in regular session, Monday evening, October 13th, at eight o'clock in the court house, L. C. Taylor, president, in the chair. The minutes of the September meeting were read and approved. The bills of the secretary for stamps and janitor services were read and ordered paid. The regular order of business was suspended, for the amendment of the constitution to conform with that of the State Society, in regard to admitting other than graduates of regular schools as members of our Society. The motion was lost. The application of W. B. Pickrell was voted down.

S. E. Munson presented the following resolution in regard to the death of Dr. Frank Fisher, and was adopted:

Whereas, Frank Fisher a member of the Sangamon County Medical Society, died at his home in Springfield, Ill., June 21st, 1902. Dr. Fisher had been engaged in the active practice of medicine only a few years before his death. Following his graduation he was appointed to service in the Wabash Hospital in this city. After leaving the hospital he opened an office and began the regular practice of medicine, and

at the time of his death he left a wife and one child.

As an indication of the high regard and esteem, in which Dr. Fisher was held by the physicians of this county, he was elected secretary of the Sangamon County Medical Society, and was filling this office at the time of his death. Therefore be it

Resolved, That by the death of Dr. Fisher this Society has lost one of its most efficient officers, and one of its most esteemed members.

Resolved further, That we extend to the wife and family of the late Dr. Fisher, our profound sympathy in the great loss they have sustained.

Resolved, That these resolutions be spread upon the minutes of this Society and a copy of the same be furnished his wife.

Signed by Committee.

The communication of C. E. Black of Jacksonville in regard to the new law, was read, after which A. L. Brittin offered the following resolution and it was adopted.

Resolved, That the Sangamon County Medical Society heartily approves of the law proposed to be submitted to the next legislature and pledges the personal efforts of its members to secure its passage.

Resolved, That the treasurer be authorized to pay to the order of the chairman of the Legislative Committee the sum of \$35 to be used in the campaign of securing the passage of the new law.

The next being the annual meeting, the president, secretary and board of directors were authorized to arrange for same.

The literary exercises were composed of a symposium on **Typhoid Fever**, of which the following is a brief synopsis.

**Etiology**, S. E. Munson. The sole cause of every attack of typhoid is an infection of the body, by a definite pathogenic bacillus, the so called typhoid bacillus discovered by Eberth, Koch and later by the researches of Gaffky and others. All the excretions of a typhoid patient contain these bacilli, sometimes long after they are convalescent. An infection of typhoid may occur from water, air, contaminated earth or flies; these germs maintain their vitality for months in water or earth, thus vegetables, not thoroughly cleansed may be a source of infection. All excreta from a typhoid patient should at once be disinfected by sulphate of copper, one pound to two and one-half gallons of water, after standing for fifteen minutes it can then be disposed of in a proper manner.

As to the **pathology**, M. T. Shutt stated that the lesions of typhoid are found in the lymphatic system, especially in Peyer's patches, mesenteric gland and the spleen, but nearly all the organs of the body may be affected by the disease or its complications.

A. L. Brittin stated that the **complications** were divided into two classes, medical and surgical. First we note the variations of the onset, in some instances it is very mild, in others so very virulent as to practically overwhelm the patient. The cerebral type is most often found in children terminating fatally. After the disease is well developed we meet with delirium, gastro-intestinal symptoms, excessive tympanitis, diarrhoea, intestinal hemorrhage and perforation of the bowels. Inflammation of the

parotid glands often occur at this stage. While the patient is convalescent we may have post febrile mental disturbance, delusions and hallucinations. Under the surgical complications, we find disease of bones, joints, abscesses, gangrene, phlebitis and spontaneous dislocations of large joints.

**Treatment** A. D. Taylor; there is no drug known to possess positive curative properties in typhoid. Attention must be given to details of general management and the nursing. An intelligent nurse should be in charge to follow the instructions of the physician. Strictly liquid diet should be maintained from start to finish, the quantity after ten or twelve days may be carefully increased if indications permit. Borolyptol or boracic acid may be used for a mouth wash. Acetozone, calomel, salol or sulpho-carbolate of zinc may assist as intestinal anti-septics. For the fever, in the hands of a skilled nurse, cold sponging has a favorable influence. Frequent examination of the patient must be made to detect complications that may arise, treating them as indicated.

D. M. Otis being absent the diagnosis was not given. The papers were lengthy and each subject was gone over thoroughly. In the discussion S. R. Hopkins spoke of the antitoxine treatment of 90 cases in Paris with good results. The post febrile condition often found was spoken of by several of the members. B. B. Griffith spoke of 90 cases treated by C. H. Louis of New York whose treatment consisted of large quantities of acidulated water with about two grains of calomel a day as needed, the diet being a pint of milk with as much vichy water, with good results. There being no further business the Society adjourned.

Percy Louis Taylor,  
Official Reporter.

**The St. Clair County Medical Society** held its regular quarterly meeting September 4, 1902, at Priester's Park, Ill., with President Fairbrother in the chair, and the following members present. Irving, Hertel, Hanson, Raab, Gunn, Waugelin, Rembe, Fulham, A. M. Kohl, Hilgard, Adams, Wiatt, Rendleman, J. Kohl, Hansing, Lillie and Portuondo, and as visitors Drs. Campbell, Cox and Zimmerman.

The minutes of the preceeding meeting were read and approved.

Treasurer's report was received and approved. Applications for membership were received from H. Reis, R. L. Campbell, F. E. Cox, J. O. Buttler and F. E. Anten. On motion the rules were suspended and the gentlemen elected to membership by acclamation.

The treasurer was instructed to notify all delinquent members of their arrears and to cancel all arrears previous to 1898.

The president and treasurer were empowered, at their discretion to cancel all arrears due the Society from members financially embarrassed.

The feature of the meeting was a very able, practical and interesting paper by Dr. Campbell on **fractures of the femur**. The essayist covered the ground very fully and illustrated the points brought out in his most excellent paper by means of radiographs and gave also a practical demonstration of the use of various

splints especially the Hodgen which is the one that he favors. The discussion that followed the reading of the paper was participated in by most of the members present.

Dr. Cox suggested the use of the vertical extension for children.

Dr. Wiatt favors the Hodgen splint.

Dr. Rembe: "I always use the Hodgen splint. In a case that I have had lately, after waiting for three weeks without any evidence of union. I put the case in a so-called Ambulatory splint with very good results. The splint was put on while the patient was in bed and he was kept there for 10 days. After that he was up and about. The fracture has united and the patient is still wearing the splint.

J. Kohl. There is no better splint for these cases than Dr. Hodgen's and I do not believe that a better one could be devised. I have never had shortage of the leg in any of my cases, fracture of the neck of the femur not excepted. I do not believe we ought to have any. We can so regulate our extension as to avoid shortage. What we have to guard against with the Hodgen splint is too much extension there is no fear of having too little.

Dr. Raab. I believe that a shortage of one-half an inch or so is very frequent if it is not the rule and I think that this is the accepted view of all medical authorities.

Dr. Adams related two cases of fracture of the femur. In one case the bone was broken at the junction of the lower and middle third. The patient was very restless and there was one-half inch shortage. The other case was one of fracture of the neck in a boy and there was no shortage. He considers the Hodgen splint as the best one for fractures of the femur.

It gives almost absolute freedom to the patient and as a result of it, comfort and relaxation of the muscles. It is also very easily applied.

Dr. Fairbrother: I have used the Hodgen splint since 1870, but have not had the good results claimed by Dr. Kohl. In the Pennsylvania Hospital they expect one-half inch shortage. I always tell my patients to expect shortage. There is generally an outside bulging in these cases after the fracture has united, but we expect it to disappear in a year or so. I do not expect union in these cases until the end of the sixth week. It often happens that when our patient is well for a time we find that there is more shortage present than there was when he was discharged. I always keep the splint on my patients for 10 weeks if they are over 30 years old.

Dr. Hanson related a case seen with the late Dr. Mudd, where there was a shortage of two inches. This case was one of delayed union.

Dr. Zimmerman. We should never try to elicit crepitation in these cases. I know of no better splint than the Hodgen. The patient is not only perfectly at ease with it but the bed pan can be used with the greatest facility.

I do not believe in perfect results in these fractures. If the cases are properly measured a more or less pronounced shortage will be found.

Dr. Campbell in closing related a case of



fracture of both femurs. In one there was non-union while in the other the results were perfect. The non-united bone was sutured with a wire suture and in due time a good union was obtained. In one case the fractured leg was one-quarter of an inch longer than the other one. In this case too much extension had been used. He generally expects shortage of the leg and so informs his patients. He does not favor the ambulatory splint. He has used it but once but the results not being satisfactory he changed it for a Hodgen.

Julius Kohl presented a specimen of cancer of the cervix that he had removed from a woman 58 years old.

Dr. Lillie reported a case of meningocoele. The tumor was as large as the child's head. Patient three days old was operated upon and the results so far are satisfactory. The operation was performed but a few days ago.

The Society adjourned to meet again the first Thursday in December.

B. H. Portuondo,  
Official Reporter.

The Chicago Medical Society now issues its program of meetings in the form of a bulletin, the Secretary, Frank X. Walls, 4307 Ellis avenue, being the editor.

The program for October 1st was:

1. The Typhoid Fever Situation in Chicago.  
Arthur R. Reynolds
2. Etiology of Typhoid Fever. W. K. Jaques
3. The Occurrence of Typhoid Bacilli in the Urine during Typhoid Fever.  
Adolph Gehrmann

4. Typhoid Bacilli in the Blood. A Preliminary Report of 56 Cases.  
E. K. Kerr and F. G. Harris

5. Complication and Accidents of Typhoid Fever.  
J. H. M. Otrodoovoc

The program for October 8th was:

1. By invitation, Jno. C. Monro of Boston will address the Society on the surgical treatment of hemorrhagic pachymeningitis.
2. The Relation of pulse, temperature and respiration in Typhoid. R. B. Preble
3. The Widal Reaction in Infancy and Early Childhood. F. S. Churchill
4. Typhoid Fever in Childhood. I. A. Abt
5. The Prognosis of Typhoid Fever.  
W. E. Quine

6. The Dietetic Management of Typhoid Fever.  
Frank X. Walls
7. The Treatment of Typhoid Fever.  
H. B. Favill.

The program for October 15th was a meeting in Mercy Hospital where Prof. Adolph Lorenz addressed the Society on "The Treatment of Congenital Dislocation of the Hips." In connection with his address he operated on a case of congenital hip dislocation.

President W. A. Evans called the regular meeting of the Society to order at 8 p. m., and stated that all regular business would be postponed until next week, as Dr. Lorenz would demonstrate his method of reduction on several cases.

Before starting to work Dr. Lorenz read a short paper explaining his method, after treatment, and results up to date. He said he had

been persuaded to give up his former operation by the uncertainty of result which it afforded. Not only was the open wound communicating with the new joint a constant source of danger, but the multiple tenotomies which his previous operation required rendered everything uncertain, as he would find when too late that sometimes he had cut too much, sometimes too little.

As he expressed it, when he used his open operation he could not sleep at night, but since he introduced his bloodless method he had ceased worrying. He has used his present method on over 1,000 cases so far, and the results have been gratifying to him.

#### First Case of the Evening.

Speaking of the first case which he presented last night—a bilateral dislocation—the first he has had in Chicago—in a girl of 5 years, Dr. Lorenz said that bilateral dislocations were far more difficult to reduce than unilateral ones. As a rule the acetabular cavity is shallower and and it is far more difficult to keep the head of the femur in its place. The age limit in bilateral dislocations is 8 years; in unilateral cases 10 years. The extreme age of any of Dr. Lorenz's cases was a unilateral dislocation of 23 years' duration.

Bilateral dislocations have the same after treatment as the single cases, and while the children can hardly walk with both thighs bent at right angles to the body, they are placed astride of little go-carts or velocipedes and push themselves along the floor.

Inside the padding under the plaster cast a strip of cloth is left, which can be rubbed, by pulling on the ends, over all the surface inclosed by the plaster. This keeps the skin clean and healthy. As the first cast put on is left undisturbed for fully six months the importance of this measure is apparent.

Dr. Lorenz stated that in his opinion the shrinkage of the soft parts around the great trochanter was a great factor in maintaining the head of the femur in its new position, hence the long use of the cast.

While the cast itself is removed in six months, the position of the leg in extreme abduction is only abandoned by degrees, this being permitted at first only in the day time, and then only to such an extent as will permit the child to walk with a bent leg. At night it is again harnessed into its position of right angled abduction.

The return of the leg to its normal position is accompanied by gymnastic movements, consisting of extension to an extreme degree. These are always carried on in the frontal plane of the body, as any extension in the sagittal plane is liable to throw the head out of the acetabulum.

#### Case of Great Difficulty.

The second case treated was one of extreme difficulty, and it was only after Dr. Ashley, his assistant, had made extension with all his strength by means of a woolen harness that Dr. Lorenz was able to produce reduction. He said, however, that these severe cases had their advantages, as, once reduced, they had a much more stable position than the easier cases.

The doctor related the history of a case which was brought to him from Finland, in which, tempted by the stability of the reduction, he



had permitted the leg to be dressed in the long axis of the body, this, of course, being much more comfortable for the child. The case returned in six months with recurrence. Ever since this every one of his cases was dressed at right angles to the body, and every one wore the cast for six months.

#### Case of Long Standing.

Just before leaving a case of seven years' standing was brought which Dr. Lorenz refused to touch. He said it belonged to a class of cases which it would be impossible to reduce without a course of preparatory treatment consisting of numerous tenotomies and graduated gymnastic movements.

At Dr. Murphy's suggestion a rising vote of thanks was given Dr. Lorenz as the clinic closed. Report taken from Chicago Tribune.

The Membership Committee reported on the following applications: L. A. Kierulff, Fred Baumann, Michel Getz, F. B. Knudson and H. F. Goodwin.

M. Sahud, Lewis K. Beck, Richard H. Street, H. Preston Pratt, Edward Lyman Denison, Ernestine Drychert, Mark T. Goldstine, James G. Mastin, Rosalie M. Ladova, A. Merrill Miller, F. W. Clement, William Arthur Porter, Chas. F. Stolz, M. G. McHugh, Edw. C. Greenebaum, Andrew A. Conlon, W. S. Duckett, G. C. Shockey, Alex. M. Stout, Chas. C. O'Byrne, H. E. Connor, F. G. Harris, J. H. M. Otrodovoc, P. T. Burns and Emma M. Moore.

J. H. Stowell gave notice of the following amendment of the by-laws: That article IV of the By-laws be changed so as to read:

"The membership fee shall be \$5.00, which shall pay the subscription to the Bulletin and all other dues for the fiscal year in which the member is elected. The subscription to Bulletin shall be 50 cents. The annual dues shall be \$4.50. No member who shall be in arrears for dues at the time of the annual meeting shall be entitled to vote, and if any member fails to pay his dues for two years he shall stand suspended, but any member who has resigned or been suspended may be restored to membership by the executive committee of the Society upon the approval of the membership committee and the payment of all arrearages."

**The Physician's Club of Chicago** held its regular monthly banquet September 29, 1902, at DeJonghe's Cafe. Frank Billings presided. The topic for discussion was **The Present Epidemic of Typhoid Fever in Chicago.**

Edwin Q. Jordan, associate professor of bacteriology in the University of Chicago, the first speaker on the program, discussed in a broad way the contention that the present epidemic was not water borne, but that it was due to dirt, infected milk, flies and other agencies. After giving some comparative statistics he said that there was undeniably an epidemic at the present time. In two months there were 343 deaths from typhoid whereas in the twelve months of 1901, there were altogether only 339 deaths. He did not agree with the assertion that it was not primarily the water that was at fault. Secondary infections may arise through the agency of flies, dirt, etc.,

but primarily the disease always was dependent upon contaminated water. Contamination of the drinking water is the real source always of typhoid fever and no amount of side reasoning or apparent exceptions have yet disturbed the truthfulness of that assertion. There is no record of any other source of the disease anywhere in so large a number of cases. Statistics show that about 70 per cent of cases are due directly to the drinking water, 17 per cent to contaminated milk and the remaining 13 per cent to various other agencies. These agencies, milk, flies, dirt, etc., have all been contaminated by contact with impure water. In cities where sand infiltration is employed to purify the water supply, there is never such marked death rate occurs as here in Chicago. And finally the local conditions and the temporary changes which they now and then undergo all indicate the water supply as the real cause of the epidemic. The drainage into the lake along various parts of the shore and the contamination of the lake water by vessels and other sources of filth, continue and probably will continue to render impure the city's drinking water. This is probably only the forerunner of other epidemics which will arise in spite of the much good hoped for from the drainage canal. The speaker was not very sanguine about the ultimate good results to be obtained from this great piece of engineering. There is much area, outside of the drainage district, as for instance the vast Calumet area, south of 87th street, which will continue to pollute the lake water and poison the various intakes as for instance the one at Hyde Park. There are certain large populous areas also north of Chicago which pour their sewage into the lake and which the drainage canal will not touch. Hence all these causes working together, the extra drainage areas, steamers, excursion boats, etc., etc., will continue to render Chicago's water supply dangerous in spite of the relief obtained by means of the drainage canal. This canal in the opinion of the speaker, will not solve the problem. It has already cost \$36,000,000 (the original estimate having been \$18,000,000) and we are in the midst of an epidemic and it is far from being complete enough to accomplish what it is expected to do. If the vast Calumet area south of the city is made into a drainage district an additional enormous expense will have to be incurred. The proper method of giving a city pure water supply under the conditions here in Chicago would be by purifying the water by means of filtration before distributing it. This method has proved effective elsewhere and would prove effective here. It has been calculated that the cost of this method is about \$5 per inhabitant which for Chicago would make a total cost of about \$12,000,000 for the establishment of a filtration plant. The speaker reiterated that he feared this would not be our last epidemic, and in closing he suggested that the experiment he made for the Hyde Park intake, of establishing a sand filtration plant. It would not be as expensive as connecting this vast area with the drainage canal.

The next speaker was John H. Long, professor of chemistry in the Northwestern Medical School. With the aid of a large map, Dr. Long explained how the various parts of the city

received their water and how they got rid of their sewerage. He agreed in the main with Dr. Jordan that the drainage canal will not entirely solve the problem. He gave some interesting and amusing reminiscences when the lake water supply was much worse than it is today. The lake is undoubtedly one cause of typhoid epidemics like the present, but it is not the only cause. This is clearly shown by carefully examining the mortality curves issued by the health department each year with the condition of the water as shown by the daily examinations. No regular parallel can be drawn between for the respective years. Some years there is a great divergence and marked discrepancies appear, hence the condition of the lake water will not entirely explain these outbreaks.

The speaker then discussed the views of Victor Vaughn and others in regard to the harmlessness of the so-called bacterium coli. He said that an increase in the number of bacterium coli in any given specimen of water is no argument that such was essentially bad. Along with the bacteriological examination of the water should always go the chemical. Oftentimes much more may be learned in regard to the purity of the water supply from the latter than from the former. The former is often hard to make, the latter is generally very easy. Here the speaker discussed briefly the simple methods, and their advantages of making a chemical analysis of water. The daily analyses made by the health department he had found to be very correct and reliable. The various analyses that we made possess a value in accordance with the interpretation put upon the findings. It is these interpretations that lead to the apparent errors and discrepancies in various series of reports and statistical curves for various years. Due weight should therefore always be given to all tests chemical and bacteriological.

That the lake is not the only sinner in regard to the present epidemic, it is to be noted that the disease is most prevalent where the water supply is shown by analysis to be the best and vice versa. Hence something else must be looked for as an explanation. Perhaps the contamination is severer, due to the backing up of the water in the catch basins, etc., thus causing food, vegetables, house utensils, etc., all to be agents in spreading the trouble.

Mr. E. G. Cooley, superintendent of the Chicago public schools, the next speaker on the program, was unavoidably kept away.

Adolph Gehrmann, formerly director of the bacteriological laboratory of the Chicago health department, the last speaker on the regular program, said that he believed the whole trouble was to be attributed directly to the water supply. This was the first epidemic to occur since the opening of the drainage canal. On Oct. 25, 1895, before the Chicago Academy of Sciences, he had declared that the drainage canal would not afford an adequate remedy for the troubles arising from Chicago's water supply. The past summer has verified what he then insisted upon. To get pure water we must stop the pollution along the shore and until we do this we will not be entirely safe from future epidemics. The present epidemic originated or had its

initiation in the excessive fall of rain during the months of May, June and July. At present the epidemic is distinctly declining and if the rainfall does not again become excessive, the normal will be reached in regard to the mortality curves of typhoid fever. The rainfall has been about 17.31 inches. In 1892, in May, June and July, there was a rainfall of about 19. inches. There were 179 deaths as against 193 deaths in August of this year. The deaths were mostly in the river districts, the Ghetto, the Fifth Sanitary district. He believed that in these districts the relatively larger amount of ignorance, the people not reading the papers and observing the instructions of the health office so closely as in other districts, has had much to do in causing the larger mortality here. Moreover here the general sanitary conditions are poor as compared with other parts of the city. All infected water is dangerous and with the unusual oscillations in the lake levels of the past summer, there is a backing up of impure water and in those districts where there is the greatest ignorance and carelessness, there is the largest amount of the disease. This summer there were ten distinct oscillations in the level of the lake with a corresponding increase in the flushing of the sewers. The difference between the summer and winter infections is interesting and worthy of study. In summer the sewerage poured into the lake is much more rapidly purified than it is in winter, hence there is more of a correspondence between the winter than the summer curves of mortality and water analyses. Hence there are short, sharp, infections in the rapid periods of summer as compared with those of winter. The principal remedy in sight is the completion of the intercepting sewer. When this is accomplished there will be a more stable state of affairs. In regard to the Calumet region, the question is not one of hard engineering as it is one of financiering. The people in that district are relatively poor and unable to bear the tax. He believes that the Hyde Park tunnel should have been blown up after Hyde Park had united with Chicago and the four mile crib should be used.

A general discussion followed the regular program, participated in by Isaac N. Danforth, C. S. Bacon, C. A. Parker, C. W. Courtright, C. Wagner, L. H. Mettler, A. C. Cotton, R. H. Carr, Frank Billings and D. T. Nelson.

The general trend of the discussion was that typhoid fever is permanently a water-borne disease; that the present epidemic is primarily due to the contamination of the city's water supply with sewerage; and that the drainage canal from all appearances, will not prevent the outbreak of future epidemics. Much indignation was expressed that Chicago, the second city of the Union, should in spite of its vast expenditures upon the canal project, find itself the victim of a severe epidemic and be obliged to send its children to school with bottles of boiled water under their arms. The canal is regarded as a most expensive experiment; as too much under the control of political influence; and as not a very promising remedy towards improving the city's water supply.

L. Harrison Mettler,  
Official Reporter.



# The Illinois Medical Journal.

The Official Organ of The Illinois State Medical Society.

New Series, Vol. IV. }  
No. 7. }

Springfield, Ill., December, 1902.

{ SUBSCRIPTION  
\$3.00 A YEAR. }

## SENILE PNEUMONIA.\*

BY DAVID W. REID, M. D., JACKSONVILLE.

As used in this paper, Senile Pneumonia means acute croupous or lobar pneumonia as it affects the aged.

The importance of a disease depends upon its frequency and its mortality. Recent statistics in large cities show that the death rate from pneumonia is greater than from any other disease, not excepting tuberculosis. Pneumonia is always a serious disease, but pneumonia in the old is so different from the same disease in the young adult as to require different rules of diagnosis and prognosis, and to call for different tables of mortality.

Old age is the goal toward which we are all traveling, not as willing pilgrims, but like exiles driven before the scourge of Time to the Siberia of wintery desolation. In view of this fact it is surprising how little has been written concerning this phase of a disease that in the suddenness of its onset, the number of its victims, its high mortality and its tragic brevity is without a peer.

**Etiology:** Although we recognize the pneumococcus of Fraenkel as the most common cause of pneumonia, there is still much to be learned about the real cause of this disease. For instance, we do not know yet, why, when the pneumococcus is ever present, in the dust, in the air, and even in the healthy trachea and bronchus, so few, relatively, take the disease. Pneumonia is undoubtedly contagious, yet most people do not take it even when nursing pneumonic patients. Still a far greater percentage take it when thus exposed to the contagion than take it from the omnipresent germs of the disease. The fresh, growing germs from a new culture growth in the sputum of a pneumonia patient are certainly more active

and noxious than the latent germs found in the air we breathe. Like a new crop of yeast cells, they increase with far greater rapidity and consequent toxicity. As contagion is always a conflict between the attacking and the resisting power, the question of the virility of the germs probably enters largely here.

So much for the invader, now when the resisting power is lowered along certain lines, as yet not well defined, the subject suffers from an "attack of pneumonia." As in war, an enemy may be weak enough to invite attack, yet strong enough to ultimately repel the invader. The fact, then, as well as the outcome of an attack of pneumonia, probably depends upon the coincident relative virulence of the attacking and the resisting elements in the conflict. Age is the most constant source of weakness in the defense. It not only invites attack, but lessens the resisting power all along the line. Even after the crisis, if it come, the organization may be so badly demoralized that it cannot adapt itself to the altered condition of things, and may succumb from internal dissensions and the added labor of reconstruction.

We say that age is the most important element in etiology as well as in prognosis. Still an old man may resist pneumonia, while a young man in hitherto perfect health succumbs. Either the invading force is stronger in the latter case, or else the old man is stronger along essential lines of resistance than the younger. Until we have made a more thorough study of the normal changes pertaining to advanced life, and have determined more accurately just what are predisposing conditions in young adults, we cannot be certain whether it is the general lowering of vitality incident to age, or some one or more conditions more frequent in old age, but found also in the young, that predisposes to pneumonia. There is more, perhaps to be learned about the real causes

\*Read at the 52d Annual Meeting, Quincy, May 21, 1902.



of pneumonia than of any other common acute disease. Certain it is, however, that from our present standpoint, age is the one factor of importance. Of course age is not always reckoned in years, still, in pneumonia, as in life insurance, years are the readiest index to age where large numbers are concerned.

**Symptoms and Course:** There are two well known types of fever often used as standards of reference, typhoid and pneumonic. Some alkaloids act always in proportion to the dose given. Others are cumulative in their action. It would seem that probably microbial toxins act in the same manner. Thus, typhoid fever acts in proportion to the lesions found. The pulse and temperature keep pace with the formation of toxic products. In many cases of senile pneumonia the symptoms assume this type as distinct from the fulminating sthenic pneumonic type, in which we have the sudden invasion of an overwhelming cumulative force.

There is no more accurately defined or better known disease than pneumonia as it occurs in the young adult and is described in the books. A hard chill, followed by a high fever, a pleuritic pain, a distressing cough, a rusty sputum, a pneumonic flush, accompanied by physical signs that are easy of recognition, form a picture that in most cases is mistakable only through gross carelessness or inefficiency. This is the pneumonia of the books. But in senile pneumonia, all may be changed. The picture may differ in almost every particular from the one just given. The disease is often insidious in its beginning. A pneumonic flush is often the first objective symptom noticed. It is often difficult for the patient to say exactly when the trouble began; or even if sudden in its onset, it may be several days before any definite lesion can be detected or even suspected. A senile pneumonia may be mild in all its symptoms and still prove fatal.

The chill of old age is more frequently absent than in youth, but when a chill does occur it is of far greater diagnostic importance than in younger life. A decided chill

in an old man generally means pneumonia, even if not followed by a high temperature.

Pyrexia in old age is never excessive. A temperature of 102° may be considered as of serious import. Fever either with or without a chill is always suspicious of pneumonia in the aged.

The pulse has a fictitious hardness and should always be taken at the heart. The respiration is rapid but not difficult. In asthmatic patients it may even be improved.

Pleuritic pain often exists, but is never the same pronounced symptom as in sthenic cases. It may be the first and for a time apparently the only symptom, excepting the ever present but frequently overlooked prostration. If a previously active old man seems perfectly willing to remain in bed, it is well to think of pneumonia, even though there does not seem to be much the matter with him.

The cough is often scarcely noticeable. Indeed a bronchitic or a tuberculous cough may even disappear upon the advent of pneumonia. The pneumonic process seems to act as an obtundent and allay the irritation that produces cough. As the amount of expectoration is dependant in great measure upon the cough, suppression of the cough means absence of expectoration. Both cough and expectoration may cease suddenly at any stage of the disease. The character of the expectoration is of great importance. The extreme tenacity of the sputum, and the difficulty, the exhausting effort with which it is raised; clinging to the teeth and tongue until forcibly expelled or withdrawn, and adhering to the receptacle, are to my mind of far more diagnostic importance than the presence or absence of the classical rusty sputum. The latter may be absent in senile pneumonia, and it may be present in passive pulmonary congestion with the weak heart of advanced life. I have found it far from being a pathognomic symptom in old people.

The crisis may or may not be well marked. A critical diarrhea sometimes takes the place of a critical sweat. Time and again I have seen an old person's temperature fall to normal, at the crisis, then gradually rise,

and the system succumb a week later under an ineffectual attempt at reconstruction.

An old man may die suddenly, quietly, unexpectedly, within a few hours after what seems to be the onset. Most sudden deaths in the aged are from this cause.

If so many of the symptoms of pneumonia are absent, why call it by that name? If pneumonia is a general disease and consolidation of the lung but one symptom, this question is pertinent. But if, as we are coming more and more to believe pneumonia is a local infection—not always confined to the lungs, however—with general toxæmia, a physical examination or an autopsy that shows pulmonary hepatization is taken as conclusive proof of the disease, even in the absence of all other symptoms. In this connection I wish to quote some forcible statements that require higher authority than mine.

Loomis said, years ago, "Senile pneumonia may run its course without expectoration, dyspnea, flushed face or physical signs. Of all acute diseases of advanced life, pneumonia is the most frequent, causes the highest temperature range, and the greatest prostration. When an old person has a slight rigor, followed by a febrile movement attended by great prostration for which there is no explanation, pneumonia may be suspected even though all other symptoms are absent."

Tyson says, "Pain, especially, may be absent, as also cough and expectoration, so that the lungs should be examined in all ailments of the old, as pneumonia is often overlooked in these subjects. Nay, more, even the physical signs may be absent in the old, and they are especially apt to be delayed in their development."

Roger says, "Pneumonia is quite frequently latent in the aged. No reaction is produced; the patient sits up, leads the same life as on previous days, then suddenly becomes ill, and succumbs in a few minutes. The autopsy shows gray hepatization of one lung, having developed without giving rise to a single symptom."

And so we might multiply authorities to prove that in many cases pneumonia is not

accompanied by the ordinary symptoms of what we know as pneumonia, and may be therefore, and probably often is, overlooked.

Theoretically the examiner should divest himself of all suspicions in advance as to the result of an examination, but in practice, a chronic suspicion of possible pneumonia in all obscure ailments of advanced life will often save the doctor's reputation, if not the patient's life; and as the professional interests of the physician are always ignored by the laity, it is well when the interests of both parties are advanced by greater care and a more thorough study of the case.

It is highly probable that the increased mortality rate of pneumonia as shown by the statistics of recent years, is largely due to diagnosis of senile pneumonia that was formerly overlooked. Some years ago, when "la grippe" first made its appearance as an annual visitor in this country, there was a great mortality among old people. Thousands of deaths were accredited to "la grippe" that should have been written senile pneumonia. I believe that most, if not all the fatal cases of influenza are complicated with pneumonia. When death knocks at the door of an old man in the winter time, if you will search carefully, you will find that the visitor has a case of pneumonia hid away in one corner of his gripe.

Prognosis: Between ten and forty almost all uncomplicated cases of pneumonia recover. After forty, each decade has a death rate of its own. After sixty, the outlook is always unfavorable. After seventy, the mortality is appalling. It has been estimated on good authority that nine-tenths of all deaths after seventy-five are from this cause. So prevalent and so fatal is pneumonia at this time of life that it has been called "the natural end of the old man." It is facts like these that give to senile pneumonia an interest that does not by any means attach to the disease as a whole.

In diagnosis we must look to the lungs, but in prognosis the heart is everything. There is much difference of opinion as to the exact cause of heart failure in these cases. As it appears to me, most writers lay too much stress upon dilatation of the

right heart from over distension, caused by the extra force necessary to drive the blood through the consolidated lung tissues. But the blood, as a matter of fact, is not forced through a resisting lung. Part of the pulmonary circulation is as completely cut off as if a branch of the pulmonary artery were ligated and the heart force is not spent in a vain endeavor to overcome this resistance, but the blood, somewhat increased in volume, passes through the unobstructed branches. It is probably the weakened, poorly nourished, intoxicated condition of the heart walls that permits dilatation from ordinary exertion. Where there is an insufficiency of the heart muscle already existing, with perhaps valvular disease or arteriosclerosis, as we so often find in the aged, the effect is disastrous. Another source of danger is paralysis of the vaso-motor centers from pneumococcus sepsis. This probably complicates all cases and is often of itself sufficient to cause death. To speak of the contributory causes would be to bring in all the vital organs of the body, especially the kidneys.

As to Treatment: I do not quote authorities, but give what seems to me the present status of opinion of writers on the subject. Many authorities hold that pneumonia is a self-limited disease, and that no known medicine can alter its course or shorten its duration. Except to meet certain indications as they arise, medicines are of questionable utility in any case of pneumonia, and they are doubly so in senile cases.

There is scarcely a remedy that has ever been used to allay pain, reduce temperature, alleviate cough or stimulate a flagging heart that has not been advocated by good authority and denounced by equally good in the treatment of pneumonia. Aconite, veratrum, antipyretics, venesection and all depressent measures, whatever may be said in favor of their doubtful utility in sthenic cases, are contra-indicated in senile cases. The same is true, except in rare cases of opium. Hyperpyrexia is never, and pain seldom a prominent symptom, consequently we dispense in advance with many remedies and the treatment turns upon supportive, eliminative and stimulative measures.

Digitalis would naturally be thought of *a priori*, as useful in this affection, combining as it does, a stimulant and an eliminative action; yet this drug has fewer friends than formerly, and if used at all, should be used with great caution.

Alcohol, even in large quantities if necessary, is advocated by most writers and denounced by some, and if ever indicated in pneumonia should be of service in senile cases.

Carbonate of ammonia has failed to hold its own in recent practice. Creosote has its enthusiastic advocates, but, together with the serum treatment, its good effects are doubted rather than denied.

Strychnine has more friends and fewer enemies than any other drug in the pharmacopoeia. As an almost universal favorite, strychnine stands alone.

Perfect rest, absolute quiet, a well-ventilated room, uniform temperature, 65 to 70, easily digested liquid food, and intelligent, conservative treatment of symptoms as they arise will suffice for a cure in the great majority of uncomplicated cases below the age of 50. Beyond this limit the mortality will be doubled and quadrupled till we almost wonder whether the treatment has anything whatever to do with the case. Heroic treatment has no place in senile pneumonia. The feeling that something must be done is a dangerous one here. In my opinion, where life hangs in the balance, a conservative course of treatment will save more lives than the opposite course, and where the highest authorities differ as to the utility of certain powerful medicines, we may well hesitate before placing even the lightest finger touch upon the trembling beam, hoping that the scale may be turned thereby from death to life.

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## PATHOLOGY OF THE KIDNEY IN CROUPOUS PNEUMONIA.

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BY E. C. FRANING, M. D., GALESBURG.

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The kidneys are the chief emunctories for most of the poisonous substances found in the body. Speaking broadly, the presence of these toxins, though they differ chemi-



cally, has similar effects microchemically on the kidney. The congestion, parenchymatous, fatty and hyaline degenerations, swollen tufts and cell infiltration, though differing in frequency and degree, seem common to all.

Fraenkel tabulated a series of 46 cases of pneumonia following them clinically, bacteriologically and pathologically. He found cloudy swelling in the kidney in every case, differing in degree in different specimens, the degree seeming to depend on the amount of lung involvement, hence upon the amount of toxins fatal in that particular case, congestion was observed in 33 per cent of his cases.

Severe blood infiltration was present occasionally, more often isolated red blood corpuscles were found scattered in the tissues, and in a few cases, lying free in the tubules.

The tufts filled the capsule, were oedematous, in many cases stained poorly and were congested, sometimes when the other tissues were normal and vice versa. Fatty degeneration was present in two specimens. Hyaline casts were observed in many specimens and granular in a few. By using Gram-Weigert stain, the pneumococci lanceolati were found in 44 out of 46 specimens examined. Often they were isolated and identified by culture and many times by inoculation into animals. A small piece of kidney was introduced into the subcutaneous tissues or into the coelomic cavity of a rabbit or a guinea pig and caused the death of the animal in from two to fourteen days. The pneumococci were isolated and identified from the blood, organs, and point of inoculation, of the animals and demonstrated in the kidney by staining. They were found in any of the vessels, tissues and tubules, but not in the leucocytes. He demonstrated them in the kidney of a foetus, an abortion caused by pneumonia.

Although there is much literature on the pathology of the acute infectious diseases there is very little bearing directly on the kidney in pneumonia. Microscopically, the kidney in croupous pneumonia without chronic complications, is soft, swollen, and brittle. The capsule strips easily, leaving a

smooth, shining surface. The color is dark red, brownish, grayish or yellowish red, the stellate veins being sometimes markedly visible. It cuts with lessened resistance, the cut surface resembling in color the external surface, the cortex generally being a little more grayish than the medulla. When death occurs early in the disease the color is more dark or brownish red. If death occurs late the color is more grayish. A large amount of blood is generally present. About, as one to one and a half, two, or two and a half, are the relations of the cortex to the medulla, showing the enlargement of the kidney to be chiefly in the cortex. The cortex is opaque and has a boiled appearance, the cortical markings being generally distinct and the glomeruli visible as pin-point sized red specks. No changes other than congestion and oedema are observed in the medulla, the mucous membrane of the pelvis usually showing no changes.

One of the most interesting pathological conditions is the congestion. In a series of seventy-five specimens examined microscopically, an excess of blood was present in 70 per cent. The kidney may be congested throughout, in the cortex, or in the medulla only. The congestion may be confined to the Malpighian tufts alone. It may involve the arterioles and capillaries at the same time or be confined to either subdivision. In some specimens small areas may be congested extremely and the remainder of the tissues contain but little blood. The congestion may be slight, moderate, or severe. In the cortex as the vessels are cut lengthwise or across, wide streaks or pool-like spaces of blood are seen lying between the tubules. In some cases, sections cut in line of the medullary tubules, the vessels are seen filled with blood and lying along and compressing the tubules. All degrees of congestion can be seen in the Malpighian corpuscles until it obliterates the structure of the tufts. Extensive extravasation of blood occurs in 2 per cent of the cases. The infiltration occurs in areas surrounding the arterioles or it may be diffused extensively throughout the surrounding tissues, pushing the tubules aside, more often, isolated red

blood cells are sprinkled here and there in the tissues or in the tubules. In a few cases they lie free in Bowman's capsule.

An almost constant condition is the swelling of the Malpighian tufts. Many times the endothelial cells of the glomerular capillaries are swollen and oedematous, sometimes granular and the nuclei stain poorly. The connective tissue is infiltrated with cells and fluid and the fixed cells appear oedematous. In a majority of cases, encircling the tuft, between it and the capsule, or collected on one side is a granular exudate which does not stain readily. It may contain fragments of nuclei or desquamated cells. The capsule itself may be thickened, oedematous and infiltrated with cells. In a few cases some of the tufts are found degenerated into a granular mass which sometimes contains nuclei or fragments of nuclei bunched up in the center or on one side. Apparently these tufts have undergone disintegration without any reaction whatever.

Granular degeneration of the epithelium of the convoluted tubules was present in all the specimens examined, visible changes in the epithelium of the uriniferous tubules partaking in only about twenty-five per cent. All degrees of epithelial degeneration are present, from the hardly recognizable to a degree in which the tubules are filled with a granular mass without any nuclei, and these variations may be present in the same specimen. A very interesting fact is that the nonstriated end of the cells, i. e., the end toward the lumen of the tubule, is most often affected. This end of one or more cells may form a granular mass which lies in the center of the lumen of the tubule while the striated end containing the nucleus appears normal and attached to the basement membrane. Generally the whole cell body is degenerated and sometimes lies loose. In many specimens, six or eight brownish yellow pigment granules, one or two micromillimeters in diameter, are found in many of the cell bodies, either diseased or normal. The epithelium of the spiral tubules is not as often and severely affected as that of the convoluted tubules. Only where the latter are

severely involved are the former affected. Frequently, they also contain the above described pigment. The cells of the loop Henle and of the uriniferous tubules in many cases appear oedematous and swollen, and sometimes stain poorly. No changes are observed in the mucous membrane of the pelvis.

Fatty degeneration occurs in connection with granular degeneration in a large number of cases. Apparently normal cell bodies may contain large or small fat globules. More often the granular cell bodies or granular masses contain very small fat globules. Extreme fatty degeneration of very slightly granular kidneys was noticed in a few specimens. Mueoid, colloid, and amyloid degenerations were not observed.

The nuclei vary in appearance. Some appear normal, some fragmented, and some vesicular. Those that appear normal may be in a normally situated and appearing cell body, or may be surrounded by a granular mass which lies in its normal place or in the center of the tubule. In the more marked degenerated areas most of the nuclei are shrunken, irregular in outline, and are sometimes fragmented into two or more pieces which lie close together or widely separated. Some stain heavily and some so lightly that they are hardly perceptible. Some apparently lose their staining properties gradually without fragmentation. Many times they divide as a whole, and these fragments subdivide, and so on and thus disappear. Frequently the chromatin swells up and becomes dense as to undergo karyokinesis when it fragments, and these subdivide until the whole nucleus becomes granular and is lost in the granular cell body. As a rule the nuclei are better preserved than the cell bodies, probably because of their greater resisting power. The nuclei of the endothelium of the blood vessels, of the cells of the loops of Henle, and of the uriniferous tubules, are often oedematous and stain poorly, but otherwise appear normal, as is the case with the nuclei of the connective tissue.

In nearly every case the interstitial tissue shows some changes which are especially marked in some instances. It frequently appears swollen and oedematous, the tubules

being widely separated by fluid and infiltrating cells. In many cases the fixed tissue cells are distorted, swollen, oedematous, and stain poorly. Other specimens show proliferative changes, especially is this so near the capsule. Of the infiltrating cells the most constant are the plasma cells, and the mono and polymorpho-nuclear leucocytes. Specimens from the kidney of forty-five cases of pneumonia were stained twenty-four hours in polychrome methylene blue, and decolorized in glycerine-ether mixture and alcohol, and cleared in oil of bergamot. Under the low power many specimens show areas of deeply stained blue cells. These areas are generally situated in the outer zone of the cortex just beneath the capsule and many times around the Malpighian corpuscles and large vessels. More often deep blue cells were seen lying between the tubules, scattered uniformly throughout or in the blood vessels. Under the high power, many of these cells contain more or less heavily stained nuclei which contain granules and a deeply stained blue membrane. The nuclei are generally eccentrically situated in a deeply blue stained, finely, or coarser granular cell body, which, varying in amount of protoplasm, is round, oval or polyangular according to situation. Sometimes the cell body has projections resembling pseudopodia, or is much elongated as if fixed while in ameboid movement. These cells, according to Councilman, are the plasma cells of Unna. The above deeply staining areas contain many of such cells. They are found also in the interstitial tissues between the tubules, especially in some of the more oedematous parts. They are occasionally found in the vessel walls and in the vessels where the congestion is great. In a few cases they are found in the capillaries, apparently plugging them. In some cases many of these cells are present, but generally the number is not large and in some cases quite large areas have to be examined before one can be found. They are present in forty cases out of forty-five examined. Few of their nuclei are in karyokinesis.

Under the same conditions are found cells with nuclei corresponding to the nuclei of the

above cells, concentrically situated in a small amount of protoplasm, which stains light blue. Sometimes no cell body can be made out. These are the small lymphocytes and according to some authorities, the progenitors of the plasma cells. Many cells representing the transitional stages are present. Large mononuclear leucocytes are sometimes present in the congested vessels, but are not found in the tissues. In some cases large numbers of polymorphonuclear leucocytes are present, being found in smaller numbers in more cases. They are most often found in the blood vessels, but may appear in the interstitial tissues in any part of the kidney. They seem to have no relations to the degenerated epithelium, as Councilman observed they had in the kidney of scarlet fever.

Hyaline bodies, in size from that of a mere speck to a red corpuscle, are seen lying free in the connective tissues, in Bowman's capsule, in the Malpighian tufts or in the tubules. They are found many times in the bodies of the epithelial cells or in their nuclei. In some areas epithelial cells contain four or five small hyaline bodies collected in the center or at one side. These bodies are round, momogenous and take gentian violet when stained by Gram-Weigert method.

In a great majority of cases hyaline casts are found in all parts of the tubules, but more often in the collecting tubules or loops of Henle. In some cases granular casts are present.

The kidneys from seventy-five cases of croupous pneumonia were stained by Gram-Weigert method for bacteria. In sixty-five per cent of these cases, organisms were found corresponding to the pneumococcus of Fraenkel in size, shape, and staining peculiarities. They exist in the large vessels but not in the leucocytes. Most often they are seen in the capillaries, many times forming emboli, in the immediate neighborhood of which, the organisms may be found scattered in the connective tissues. They may be seen in the cell bodies of the epithelium, in the granular masses, or free in tubules. In the Malpighian corpuscles they are noticed sometimes in its connective tissues, in the capillaries, lying free in the capsule, or in the granular exu-



date. Repeated examination fails to show any organisms in those Malpighian tufts which are totally granular. The organisms are also found in all the tissues or free in the tubules of the medulla.

Summary: Congestion, more or less marked in seventy per cent; oedema in practically all that are congested; granular degeneration more or less marked in all cases; hyaline material in sixty per cent; fatty degeneration in twenty-five per cent; swollen tufts in practically all cases; infiltration of lymphocytes and plasma cells in eighty-nine per cent, and of polymorphonuclear leucocytes in twenty-five per cent; bacteria in a great majority of cases; hyaline casts in eighty per cent and granular in a few cases.

If death occurs early in the disease, the gross specimen is not so much swollen, is firmer and of a deeper red than when death occurs in the later stages, when it becomes soft, more swollen, brittle, oedematous, and acquires a more grayish tint. This is due, in the former condition, to only short duration of the congestion and action of the toxins, therefore the absence of oedema, cell infiltration, and severe cell degeneration. But when death occurs late, the continued actions of the congestion and toxins effect more marked changes.

The congestion is not due to obstruction of the renal vein as no obstruction has been found. It is not in all cases due to general venous congestion as many times the kidneys are congested and the other organs are not and *vice versa*. A nervous phenomenon cannot account for areas of congestion and noncongestion in the same specimen. Again, in some specimens the degree of dilatation of the vessels is beyond that of any normal vessel walls. So, in some cases at least, the congestion is due to weakening of the vessel walls, which is due to the action of toxins or otherwise, and the areas of congestion in some specimens are points of minor resistance.

The parenchymatous degeneration is undoubtedly due to the action of the toxins in the process of elimination. By comparing a large number of history sheets, the degree of degeneration is found to bear a direct re-

lation to the amount of lung involvement and consequently the amount of toxins to be eliminated. Slight or moderate lung involvement with early death results in only slight epithelial degeneration, or, with late death, moderate degeneration. Extensive lung involvement and early or late death result in marked or severe degeneration. This indicates that a concentrated toxic substance acting only a short time is more harmful than a nonconcentrated one for a long time.

The influences which bring about lymphocytic infiltration are uncertain. They may be either mechanical, chemotactic, or both. The peculiar situation of the deep staining areas which contain many lymphocytes, and, according to some authorities, the fact that lymphocytes are motile only under peculiar mechanical conditions would suggest mechanical influence. But these influences alone would not seem to account for the presence of all the lymphocytes, especially where they are found scattered uniformly throughout the tissues, and no congestion or peculiarities in circulation are present. So chemotaxis must be called into assistance.

As, according to Councilman, the plasma cells are somewhat more motile than the lymphocytes, their presence can be considered more active; but, because of their proportions, from the same influences as in lymphocytosis. Their proportions are tended to be kept constant also by transitional forms from lymphocytes. Very few plasma cells are present from multiplication as but few karyokinetic figures are seen in them.

The offices of the lymphocytes and plasma cells can as yet only be conjectured. They have no relation to the degenerated epithelium. They are not phagocytic as neither the lymphocytes or plasma cells have phagocytic properties, and no phagocytes are seen. As the above cells are found in all inflammatory processes with a tendency to degeneration, their presence in the pneumonic kidney may be looked upon as conservative. Just how, is not known, probably in connection with tissue regeneration or with toxin destruction. According to some authors (Schottlander' Krompecher) the

purpose of the plasma cell is to form connective tissue. Accepting this theory the plasma cell in the pneumonic kidney may be considered in connective tissue formation, as also indirectly the lymphocytes. The presence of the plasma cells, and even lymphocytes in inflammatory conditions might suggest their power to absorb toxins or to excrete substances, to neutralize or destroy them. Both processes may be in progress at the same time. The lymphocytes destroying the toxins by neutralization, absorption or otherwise, may then immigrate or be destroyed or become plasma cells. The plasma cells may enter the process of toxine destruction and later become connective tissue cells.

Fatty degeneration is probably the result of maloxidation in the metabolic changes in the cells, which is due to the stagnation of the blood, oedema, toxins, and deficient oxygen, carrying function of the blood, which according to many authorities is true of the blood in many febrile diseases, and also to loss of gas interchanging areas of lungs.

From the size and disposition of the hyaline bodies in the pneumonic kidney, they would appear to have two origins at least, possibly three as classified by Hektoen—mesoblastic, epithelial, and possibly haemic. Saltykow says that hyaline is formed degenerating red blood corpuscles, because he found hyaline bodies in the blood vessels, small hyaline bodies in the red blood cells or transitional forms from the red blood cells into hyaline bodies, and iron reaction in many hyaline bodies. Accepting his theory, the large hyaline bodies scattered in the connective tissue may be considered to be of hematogenous origin and scattered in the connective tissues in the process of attempted elimination. Thore finds a close relation between hyaline bodies and acidophile granular cells which are found in inflammatory processes. So one would presume to find in the pneumonic lung, where many acidophile granular cells are found, and by proper staining methods, hyaline bodies are found there. These may be taken from the lung by the blood and collected in the connective tissue of the kidneys. It may

be formed *in loco* in the kidney as a degenerative product of the connective tissue due to the toxins or otherwise. The hyaline bodies found in the nuclei and the mulberry form found in the epithelial cell bodies may be considered as products of epithelial degeneration or secretion.

Pneumonia cannot any longer be considered as a local infection of the lungs but frequently a bacteraemia. The pneumococci being immotile enter the circulation through some lesion, probably the ruptured vesicular and vessel walls of the lungs, and lodge and multiply in any suitable place, as in joints, heart valves, kidneys and other organs, and have been isolated from them.

#### THE TREATMENT OF PNEUMONIA.\*

BY N. S. DAVIS, JR., CHICAGO.

The mortality from croupous pneumonia has been increasing for many years; for instance, in Chicago, in 1852, deaths from pneumonia constituted 1.66 per cent of those from all causes; ten years later, 3.40 per cent; in 1872, 4.55 per cent; at the end of another decade, 6.26 per cent; in 1892, 9.14 per cent, and in 1901, approximately 12 per cent. If I had quoted the annual percentage mortality from this disease its steady increase would have been emphasized still more. However, Chicago is not peculiar in this, for statistics show that in all civilized countries pneumonia has been increasingly prevalent and fatal.

Naturally we ask who is responsible for this—the physician, the patient or the disease. Are we less successful than our ancestors were in the management of the malady?

Although the word pneumonia has been in use for many centuries, it was not confined to the specific disease which we know by that name until comparatively recent times. Prior to 1818, when Laennec made it possible to clinically differentiate the thoracic affections, it was used to name all of the severe acute inflammations of the pleura, lungs and bronchi. It is therefore

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

impossible to compare the treatment of today with that of times earlier than the end of the first quarter of the nineteenth century. Indeed the authors of many of the leading treatises upon medicine in the middle of the last century made no difference in the treatment of acute croupous pneumonia and pleurisy, although they recognized their clinical differences.

In the thirties and for twenty years thereafter bleeding was regarded as the most important measure which physicians could use for the relief of pneumonia. At first frequent and copious bleeding was recommended. Indeed, it was advised that blood be abstracted whenever respiration was excessively quick and labored, and the temperature high. It is true that a fall in temperature was thus effected and that breathing became slower and deeper and often the mind clearer. It was also insisted that, at times, if bleeding was practised early in the stage of congestion, the malady could be checked in its progress and convalescence established by the third day. But I presume many of you have seen, as I have this winter, a crisis occur upon the third day and complete recovery follow. It is doubtful if the disease has ever been "jugulated" at any stage of its progress.

Between 1840 and 1855, bleeding was recommended only in the stage of congestion and was believed to be of little use when lung tissue was hepatized. In this period, too, it was regarded as not useful when pneumonia attacked those who were weak and debilitated. Since 1860 venesection has rarely been resorted to. Unquestionably a moderate bleeding, when a large area of lung tissue is congested but not yet hepatized, is safe in full blooded and robust individuals, and it will add to their comfort, lessen pain, lower temperature, slow respiration and often unload an over-burdened right heart. Occasionally today under these circumstances, bleeding can be done with distinct benefit. Last winter an accidental hemorrhage from one of my patients showed me its utility in later stages of the disease. The patient had both typhoid fever and pneumonia of a severe type. On three dif-

ferent occasions, about three days apart, he became semi-comatose and deeply cyanotic, because of oedema of the lungs. All his symptoms pointed to a probable loss of life within a few hours, when on each occasion a spontaneous and copious hemorrhage occurred from the bowels. At once after each hemorrhage improvement set in, cyanosis disappeared, the physical signs of pulmonary oedema disappeared and consciousness returned. Ultimately he recovered from the combined attack of these maladies.

Although bleeding can be resorted to with benefit in pneumonia, it has been abundantly shown not to shorten the course of the disease or to influence the vitality of the germs which cause it. I believe it is most useful in order to unload a dilated right heart. Therefore, when the jugulars are distended and the pulse is small, comparatively soft and increasing in rapidity, when the second pulmonary sound over the heart is strongly accentuated or the lungs are filling with the coarse moist rales of oedema, it may be resorted to with hopefulness.

When bleeding was first used in pneumonia, it was because the essence of the disease was believed to be congestion and inflammation. Rasori, and his numerous followers, thought that "stimulation" was even more its essential attribute. To combat this he urged the employment of large doses of tartar emetic. Rasori used as much as 8, 10 and 12 grams of this drug per day for several days in succession. After the first doses a tolerance of it was usually acquired. That it lessened the rapid respiration, softened the pulse and quieted the patient was unquestionably true. But it also irritated and inflamed stomach and bowels, caused depression, almost a condition of collapse, and a weaker heart. The enormous doses advised by Rasori were not long used. Even Laennec, who was a staunch advocate of its employment, advised doses of not more than 1.5 grams per day, and some years later Trousseau recommended it in much smaller doses. Tartar emetic is now rarely used, and never in large amounts. Modern pathology affords no reason for its employment as a means of combating the cause of



the disease and it has been found to neither shorten the course nor lessen the mortality of pneumonia. Moreover, its physiological effects are so distressing and so enervating that it would be difficult to revive its use.

While bleeding and tartar emetic were in vogue, blistering and poulticing were also regarded as important adjuvants to treatment. Blisters, ten and twelve inches long, and five or six wide, were placed upon the affected side. They were covered and followed by fomentations until recovery or death occurred. Blisters, it is true, are particularly efficacious for the relief of the pleuritic pains which accompany pneumonia, but neither they nor fomentations materially alter the course of the disease.

Poultices which envelop the chest make respiration easier and coughing less frequent. These effects are best observed in children to whom they can be most successfully applied. It is so difficult to keep the large fomentations which must be used in adults warm, and the frequent application of new ones causes so much discomfort, that they are for the most part discarded.

In this country about the time bleeding ceased to be generally practised, *veratrum viride* began to be used in the treatment of pneumonia. It was found to diminish the tension of the pulse, lessen its rate, lower bodily temperature and provoke perspiration. After some years of trial, clinicians concluded that it too was adapted only to sthenic cases and to the stage of congestion. Numerous studies of its physiological action in the seventies and since then, have shown that it effects both the nerves and muscle fibers of the heart, stimulating the inhibitory nerve and paralyzing the muscle. There is produced by it both vasomotor and cardiac weakness and ultimately paralysis. It is therefore not a safe drug to use in pneumonia, when the preservation of cardiac strength is all important. However, it will contribute to the comfort of patients, and can be employed without hazard when they are young and vigorous, and when the area of lung tissue involved is small.

During its period of vogue, calomel was used in large doses to combat pneumonia.

But it has fallen into disuse today, for it does not shorten the course of the malady, contribute to the comfort of the patient or lessen the mortality. However, it can be employed with benefit as a laxative at the beginning of an attack or during its course.

These various anti-phlogistic measures of treatment were employed to attack the disease when it was believed to be an acute inflammation resulting from exposure to cold. That they did not modify the course of pneumonia or affect the rate of mortality, began to be appreciated about 1845, when the fact that as low a mortality was observed in the homeopathic hospital at Vienna as in institutions where bleeding, blistering and tartar emetic were used, induced Skoda to try other methods of treatment. The English speaking people were awakened to the inutility of the prevailing treatment by the writings of Bennett of Edinburgh in 1848.

As anti-phlogistic methods, the methods of offense were discarded, those of defense were adopted. However, at first remedies for the most part were applied empirically rather than with the intelligence with which they are used now.

About the end of the third quarter of the last century the discussion waxed hot as to whether the important symptoms of pneumonia were due entirely to inflammation of the lungs, or whether they were manifestations of a general disease, the pulmonary inflammation being only one element of the malady. A little later the discovery of the microbic cause of pneumonia settled this dispute.

The protective or defensive treatment of today recognizes the fact that a patient's life is endangered (1) by the toxins produced by the *diplococcus lanceolatus*; (2) by the rapid involvement of large areas of lung tissue in inflammation which makes them functionally useless; (3) by the sudden distention of the right ventricle to the point of paralysis by obstruction of the pulmonary vessels; (4) by oedema of the lungs, the result of a weak heart, enfeebled respiration, and probably of toxins which excite

oedema in tissues no longer possessing the vitality required to develop the changes characteristic of inflammation.

As yet no specific has been found to combat pneumonia, or to protect those who are exposed to it. Nor can we prevent the extension of the lung lesion from one point to another.

We know that so long as only a part of one lung is involved in a person who is young and vigorous, recovery is the rule and little medication is needed.

The general symptoms or evidences of pneumonic intoxication are in proportion to the extent of the pulmonary lesion. Therefore the gravity of the case can often be measured by it, but not always, for even death may occur when pneumonic inflammation is very limited and the amount of toxins small in one who is debilitated, and especially in one who is nervously enfeebled.

To prevent the accumulation of toxins the organs of elimination must be kept active. We do not know with certainty whether the toxins of pneumonia escape through other channels than the kidneys. However, to promote early and full evacuations from the bowels, undoubtedly contributes to the comfort and well being of patients. Therefore a purge should be given at the onset of the trouble. It may consist of calomel or a saline, or both. And the bowels should be moved regularly thereafter and kept as free from putrefying matter as possible. Digestion is always slow and imperfect in pneumonia. Consequently food, if taken in considerable quantities or in any except the most digestible form, will undergo abnormal fermentation in the gastro-intestinal tract, and produce toxins which will add to the irritation of the kidneys, already often effected by the toxins peculiar to pneumonia. Furthermore, they produce a nervous depression and lack of tone which under other circumstances we know so well as a "bilious state." Therefore it is essential that only the most digestible foods, and those least liable to abnormal fermentation, be eaten. Milk should be the chief article of nourishment. But in addition to it, broths, a little of gruels and such fruit as oranges can be

taken. During the three or four days when the disease is at its height, milk alone is the best food and only moderate amounts of it, two or three pints in the twenty-four hours should be given, but water should be drunk as freely as possible. Such a liquid diet will stimulate excretion by the kidneys and will not overtax digestion. The broths will help to restore to the blood some of the salt lost by it and deposited in the hepatized lung, which moreover is important, in order that osmosis and metabolism may proceed normally.

When the urine is particularly small in quantity and there are evidences of deep intoxication, large subcutaneous injections of physiologic salt solution often do good by provoking freer diuresis, and more rapid elimination of toxins.

Elimination by the skin should be encouraged by sponging with warm or tepid water.

Cyanosis is due in part to the hepatization of large areas of lung tissue, in part to an enfeebled pulmonary circulation, to toxæmia, and sometimes to oedema of the lungs. That which will maintain cardiac strength and vigorous breathing will arrest and relieve cyanosis. The distress which accompanies it can, moreover, be greatly mitigated by the inhalation of oxygen gas. I know of nothing which contributes more to the comfort of patients than this gas does. Unfortunately like food it will only help to maintain strength and comfort, but cannot check the progress of the disease. Therefore in the severe cases in which cyanosis indicates the employment of oxygen, it is rare that life is saved by its use although it may be prolonged.

The attention of the profession has been centered of late years upon the heart, I am tempted to say, too exclusively. And yet the maintenance of its strength and a suitable balance of arterial and venous blood is all important. If the obstruction to pulmonary circulation which exists in pneumonia developed gradually, it is probable that the heart would not be injured by it. But coming with suddenness it is especially apt to dilate and weaken the right ventricle. Dangerous distention of the heart is pro-



duced frequently when new and extensive areas of lung tissue are hepatized by an extension of the disease, for the heart weakened by the first attack of the malady cannot resist such extensions. Other factors than pulmonary congestion play a part, however, in producing cardiac weakness. The disturbed metabolism of the muscle which is incident to the febrile state and an imperfect supply of oxygen are some of them. Digitalis is more relied upon than any other drug to support the heart. But other cardiac tonics, such as caffeine, strophanthus and cactus can be used in its stead. Digitalis should be given as soon as the heart-beats range above 100 per minute. It must often be prescribed in doses larger than are commonly given, for in pneumonia a resistance to it is most noticeable.

In 1888, Petresu of Bucharest urged that it be employed in excessively large doses and lauded it as almost a specific for the disease. It was his habit to give for three or four days a tablespoonful every half hour of an infusion made of from eight to twelve grammes of leaves in 240 cc of water. He treated soldiers in time of peace who were young vigorous men when they were attacked by the ailment, conditions under which the mortality from it is always lowest. The utility of such large doses has not been confirmed, and patients found in city hospitals are unable to take even much smaller ones without exhibiting symptoms of poisoning.

Theoretically strophanthus seems preferable to digitalis, as it affects the heart with equal power, and does not contract the peripheral arterioles to the same extent, and thereby increase the work which the heart has to do.

Strychnia is another drug relied upon today, chiefly because it is the best respiratory tonic which we possess, stimulating deeper and stronger breathing. It is also a cardio-vesicular and general tonic of exceptional value. In all severe cases it must be employed when respirations are excessively quick and shallow and the pulse is fast. In the worst cases it is best given hypodermatically.

Diffusible stimulants are often needed.

Their transitory effects must, however, be remembered. The aromatic spirits of ammonia and the carbonate of ammonia are the best. The first can be given every one or two hours. The latter every two or three. They are also useful expectorants, helping to make less tenacious the secretions in the bronchial tubes and to keep them unobstructed. These ammonia compounds are prompt and efficacious in their action. They are especially indicated when the pulse is quick, small or irregular.

Alcoholic beverages have for many years been used under the same circumstances. They have been given in large amounts, so much as eight to sixteen ounces of brandy or whiskey daily. At first urged upon the profession by Todd, they were used as food as well as stimulants. Today physiologists tell us that alcohol is not a food, or if one, as some still contend, that it is of so little value as food as to be practically useless. No wonder, therefore, that experience as well as experiment have led to a lessened employment of alcoholic beverages. The best experimenters teach that the stimulant effects of alcohol upon the heart are obtained only from small doses and that they are very transitory, of about fifteen minutes duration. When large doses are given, anaesthetic effects prevail, which lessen the force of the heart, cause it to dilate more easily, make respiration shallower, and therefore increase the danger of cyanosis. From trials of it and much experience in the treatment of pneumonia without it, I am convinced that alcoholic beverages are unnecessary, that the ammonia compounds are more reliable, and that if used persistently the alcoholics do harm because of their anaesthetic and paralyzing powers. Alcoholics lessen the oxygen carrying power of the blood, and therefore increase any tendency to cyanosis. They disturb metabolism and hasten muscular degeneration. They dilate the peripheral arterioles and lessen diuresis. This enumeration of the ill effects of the doses of brandy and whiskey commonly used in the treatment of the malady, might be lengthened had I time.

When chemical antipyretics were first introduced to the profession, they were exten-



sively employed in pneumonia. But they have been discarded as dangerous. Their effect upon metabolism, by which they lessen fever, is very similar to that of alcohol, only it is more pronounced. So little are they used now that I need not explain why they have proved harmful.

Cold baths were employed as an antipyretic measure, as early as 1850, by Vogel of Berne, and later their use was urged by Liebermeister. Full tub or sponge or douche baths have been given every two hours when a patient's temperature has been above 102.5 degrees or 103 degrees. The first statistics gathered seemed to show that this treatment lessened the mortality from the disease, but more experience has not confirmed this. However, it has been shown that cold baths are harmless. Now they are used rarely in pneumonia unless there is hyperpyrexia, when ice cold baths and packs are relied upon.

Pain, coughing and weariness caused thereby often lead to the administration of opiates and other soporifics. Such drugs can be used safely only in mild cases and at the onset of the malady for later they will make respiration shallower and less vigorous, thus contributing to the development of cyanosis. They also suppress coughing and thereby lead to an accumulation of mucus in the air passages, which will interfere with breathing. Moreover elimination by the kidneys is lessened by them.

The inutility of the anti-pneumonic serums now upon the market has been recently shown by several writers and need not be considered in detail by me.

After this short and somewhat imperfect review of the treatment of pneumonia, past and present, I believe that you will agree with me that never have physicians known so much of the nature of pneumonia or used remedial agents more intelligently than now. It is not their fault that the mortality of this disease is increasing. But is the medical profession altogether free from blame for its prevalence? Prophylactic measures have not been enforced as they should have been. It is well known that the cause of pneumonia is a micro-organism in the sputa of those suffering from the disease, and that

the malady is engendered by inhaling it. Therefore the same care should be taken to collect and destroy the sputa that is taken in pulmonary tuberculosis. It is not, however, a sufficient precaution to exercise this care during a patient's brief sickness because the diplococcus of pneumonia is known sometimes to live and multiply for months and even years, in the mouth, pharynx and nose of those who have had the disease. Therefore during convalescence, and for at least two or three weeks thereafter, expectoration, if it occurs, should be into a sputa cup containing an antiseptic and water. Moreover, the patient's mouth should be rinsed several times daily with an antiseptic mouth wash. During the illness the greatest pains should be taken to prevent soiling bed clothing, carpets or furniture with the sputa. After the illness the patient's room should be thoroughly cleaned and ventilated. The enforcement of such measures will help to lessen the spread of this disease and will greatly lessen the frequencies of its recurrence in those who have had it.

The facts that "house epidemics" are not infrequent, and that the disease prevails as other contagious and highly infectious ones do in the winter season, when people are most crowded together and live much of the time in badly ventilated apartments, suggests another prophylactic measure, which the public should be taught to apply, namely thorough ventilation of houses, offices, factories, theatres, churches, cars and other public places, in order that the air which must be inhaled may be kept clean and free from infectious matter.

Laymen should be taught not to be afraid of a patient who has pneumonia, influenza or tuberculosis, but to be afraid of lack of cleanliness about him during his illness, of failure to enforce prophylactic measures and of close, badly ventilated apartments during the seasons when these diseases prevail.

Although experiments with pneumonic serum have shown that a temporary immunity can be created in certain lower animals, it can not be in man. These experimental successes, however, lead us to hope for more certain means of preventing pneumonia than we now possess.

"Masterly inactivity" does not lead to success in the treatment of pneumonia; but intelligent, masterly activity directed to the preservation of strength and amelioration of symptoms which cause discomfort, does. Above all things it should remember that it is not a Greek name which is being treated but a living man, to whose changing needs treatment must be adapted. Indeed that physician will be most successful who has not a routine treatment for the disease, but who can appreciate the condition of his patient, and who knows how to meet each condition with appropriate remedial agents.

**Discussion on the Papers of Drs. Reed, Franing and Davis, Jr.**

**M. S. Marcy, of Peoria:** The subject of pneumonia is one that we hear about and talk about at every medical society in the country. The medical journals would be incomplete without some thorough discussion of pneumonia. Truly, this is one of the most important subjects that comes before the medical profession. After hearing such learned papers as these today, it is almost absurd for me to attempt to add anything and I will limit myself to reciting my experience in some cases which differed from some of the cases referred to by the essayists.

The first essayist on senile pneumonia stated that heroic treatment was unavailable, and I understood him to say useless and wrong without exception. I feel that I must take some exception to this, and I will back up my exception by some cases that I have had. Last winter I was called to see an old lady, seventy-five years of age, who was suddenly taken with a severe chill during the evening, and at midnight, when I was called, she had a temperature of 104 degrees, pulse 100, pain in the lower left lobe. She was suffering intensely. Now, this was a case where heroic treatment had to be used or it would be useless to give anything, for in twenty-four hours she would, beyond doubt have been past the hope of any recovery. I decided to use heroic measures. I selected for my case Norwood's tincture of veratrum viride, which is no better than any other, but is always reliable. I gave my patient five drops, repeating the dose three times, and in the morning her pulse was normal, the temperature was down, the pain had all left her, and she was on the high road to recovery. Now, this was one instance where heroic treatment was the proper thing. I admit, however, that it is not proper under all circumstances, nor is it proper to give any one remedy in every case. We must select the remedy, and we must select the case. In this particular case that particular remedy was of great importance.

I wish to confine my remarks exclusively to this one remedy. I am well aware that today veratrum viride is not held in very high repute by the medical profession, but the experience I have had with this drug in the past years warrants the statement that it has given

me better results than any other remedy I have ever used. I have used it in children, during middle age and late in life, and with invariably good results. The last time I used it was in a child, two years of age. I gave three or four doses of two drops each, when the fever subsided, and the crisis was passed. I do not believe that the results are always so rapid, but I cannot help but feel that in veratrum viride we have a very good remedy for the treatment of pneumonia.

**James B. Herrick, of Chicago:** Unfortunately, I did not hear all the papers that were read, and I must limit myself to what I heard. It seems to me that if there is any acute infectious disease that is maltreated and over-treated, that disease is pneumonia. The profession has learned a lesson in typhoid fever with drug treatment, and that every treatment is not the best treatment. They have learned the lesson regarding typhoid that there is a natural history to the disease; that it runs a certain definite course, and then, as a rule, stops. With regard to pneumonia, the lesson does not, as yet, seem to have been fully learned, and so we find physicians, in fact, all of us, inclined at the very beginning of a case of pneumonia to pile up drugs that are undoubtedly harmful. The lesson must be learned, and it can be learned, that there is no specific medication, and that the indiscriminate use of remedies of any description is wrong. It is by no means uncommon to find patients with pneumonia taking sixteen different drugs in twenty-four hours. They take drugs for pain, drugs for sleep, drugs for the bowels, drugs for the tympany, drugs for fever, drugs for cough, and so on.

There are two conditions in pneumonia that we must always consider: One, the toxemia or sometimes true bacteriemia, and the other is the mechanical interference with respiration and oxygenation. The free use of water helps somewhat so far as elimination is concerned, and there are also some cases in which a good dose of calomel does as much to cure the disease as any other remedy, especially in a class of cases where we find a tympanitic abdomen and slight involuntary discharges from the bowels. In these cases a dose of calomel has, in my experience, done a great deal of good.

With me, personally, oxygen has seemed to do very little good in pneumonia, and yet there are cases that appear occasionally, cases in which the mechanical element seems to play a great factor, where oxygen can and does do some good. For instance, a case has come under my observation (some two months ago), in which a young lady had a migrating pneumonia, involving the entire right lung, and then the disease skipped to the left lung. The patient died, but I felt sure that the free use of oxygen kept her alive for at least twenty-four or forty-eight hours. There the condition was largely one of mechanical interference with respiration and oxygenation.

I agree with Dr. Davis that opiates must be used with great caution in pneumonia, and yet there are patients in whom there is great restlessness, sleeplessness, a rapid loss of strength from the lack of sleep, constant tossing about in a restless delirium, in whom a hypodermic of



morphine does a great deal of good. It certainly quiets the brain, quiets the musculature, and seems to refresh the patient by putting him to sleep.

**E. Fletcher Ingals, of Chicago:** The doctor's paper was so complete that there is little left to add. There are two or three things, however, that should have been mentioned that might be of interest. Wood has spoken very highly indeed of the salicylate of soda, and remarkable results have been reported in a number of cases which recovered. Not more than one or two per cent of deaths out of 150 cases have been recorded, in which salicylate of soda was given, about eight grains a day. I do not wish to advocate this, but the authority is such a high one that it seems to me it ought certainly to be tried. Chloroform has also been recommended very highly, and claimed to cure all cases. Neither do I advocate this. I believe that in some cases the patient receives very great relief from the use of chloroform. In cases where opiates are given, chloroform might be used with perhaps more safety.

Oxygen, I believe, will do much good in a few cases, if given early, but, like the last speaker, I have seen very little good effects follow its use. It should be given early, before edema has set in, and then it should be crowded and given nearly all the time, and not once in three or four hours, as is sometimes recommended. I recently saw a case where the attending physician thought it was too stimulating. If not given all the time, it should be given as much of the time as the patient will take it. The time to give it is as soon as the patient begins to suffer from dyspnea. I believe it would be beneficial in many cases.

As to the opiates, I want to reiterate, as the reader of the paper said, that they ought to be given with the very greatest circumspection. I have seen patients on the verge of very grave danger following the administration of one-eighth grain of morphine, and I believe that many pneumonic patients are hurried to the grave by opiates given in very large doses.

As to the use of alcohol, I think there would be considerable difference of opinion. I believe there are some cases in which alcohol should be given freely, especially if the patient is an alcoholic. The use of alcoholic stimulants, though they improve the strength of the pulse, quiets the patient and diminishes the frequency of both pulse and respiration, which I believe is very desirable. The quantity must be regulated by the results. In a patient I treated last winter, as sick a person as I ever saw, we gave from thirty-six to forty ounces of whiskey daily for four or five days, and I believe he recovered because of this treatment.

Nothing was said about the protection of the chest. In the Cook County Hospital it is the custom to leave the patient in bed with a thick cotton shirt on and nothing else. He has the same covering as the other patients in the ward, and is not protected at all. Now, I have seen a great many people who will suffer a great deal of pain in the chest or other parts of the body from exposure to a temperature a few degrees below that to which people even in health are accustomed. If this is true, I do not see why a sick person should not be pro-

tected more than a well person. I think the majority of practitioners in private practice protect the patient's chest and they do well by it.

Serum-therapy is of interest, but unfortunately it does not seem to have any very great effect, at least up to the present time none has been demonstrated. In the Cook County Hospital serum-therapy was tried several times, but we have never been able to crowd it very far. The last time we used it we thought we did very well. We used a large amount of serum, the amount recommended, but in a few days we ran out of serum, and could not get any more.

**H. B. Buck, of Springfield:** I was very much interested in the first paper, read by Dr. Reed. While I do not believe in specific medicines, as I have very little confidence in what might be called specifics, but have more confidence in nature's own efforts. Whenever she is in trouble, she does her very best to bring about a recovery, and, in my judgment, every man who gives the doses of medicine recommended by my friend is guilty of a very grave misdemeanor. Every man's ministrations should be in the way of aiding nature, helping her to eliminate the poisons, and to bring the tissue back to the normal. In some of the cases referred to by Dr. Reed, where the symptoms are slight and hardly noticeable, and where death may be close at hand, a man should be extremely careful as to his medication. There are two remedies, however, that I have used largely and for many years that ought to be mentioned at this time. One of them is strychnia, and the other is protonuclein. I cannot imagine any case referred to by Dr. Reed in his paper where those two remedies would not be serviceable if properly administered. If I had the time I could tell you of cases in which I used veratrin, not veratrum viride, I prefer the alkaloid. If you will use that remedy, no matter what the age of the patient may be, and give it up to the point of tolerance, and then adapt yourself to the conditions that may arise from that time on and not overwhelm your patient with drugs, you can use it to the best advantage. The strychnia and protonuclein, I will not explain to you how they have their good effects, but if you will remember that every cell in the body is made up of nuclein, that nuclein enters largely into its composition, you will conclude that more of the same cell-building stuff will do no harm. It is a remedy that does not over-stimulate, and can, therefore, be used freely and with safety.

**Robert H. Babcock, of Chicago:** I desire particularly to commend Dr. Reed's paper on senile pneumonia. Without wishing to be invidious in my comparisons, I mean that the subject is of such importance, and it is so likely to be overlooked, that I feel the subject cannot be dwelt upon too much, nor with too much emphasis. I should like to emphasize three points in connection with senile pneumonia. First, in the diagnosis of senile pneumonia the physician should remember the frequency with which pronounced physical signs are overlooked. If the physician in his diagnosis of senile pneumonia expects to find clinical evidences similar to those seen in the pneumonia of the young adult, he will be disappointed in the majority



of cases. The existence of the cough in the early stages of pneumonia is an extremely significant feature, as stated by Dr. Reed. Second, I desire to emphasize the necessity of taking rectal temperature in senile pneumonia, for I have many times had a trained nurse tell me that the mouth or axillary temperature was normal, and had I depended on that reading, I would have been misled. On taking the rectal temperature, it was found that the patient was actually suffering from a pyrexia, even up to 102 degrees, and often higher. Third, that the physician should always regard the prognosis in senile pneumonia as grave, no matter how trivial the case appears to be from the clinical findings. The physician should always look upon the case as a serious one. Many an aged person will recover from pneumonia, but so large a proportion of them die that I think the physician is justified in always regarding the prognosis as more serious from the start.

The treatment of senile pneumonia should be supportive and eliminative. In this connection, I must say that I cannot at all agree with the former speakers in the use of *veratrum viride* in pneumonia of the aged. I regard Dr. Marcy's teachings on that point as likely to do harm. However skillfully he may use *veratrum viride*, he should remember that most practitioners do not use it skillfully, and particularly if the patient resides at some distance from the physician's office where he cannot be observed frequently. *Veratrum* and *aconite* are very likely to prove dangerous weapons.

With reference to cyanosis in pneumonia, I desire to call attention to a cause of cyanosis which Dr. Davis did not clearly bring out, the cyanosis found in capillary paresis. Romberg's experiments have shown that cyanosis in pneumonia is due to a paresis of the vasomotor centers in the cord, and if this is true, then the treatment of cyanosis must be changed from what we have been accustomed to. The use of large doses of alcohol in the form of whiskey or brandy, in the cyanosis of pneumonia is, in my opinion, bad practice. I believe with Dr. Davis that it does harm rather than good, because it intensifies the capillary paresis already present. I agree with Dr. Ingals that there are cases, especially chronic alcoholics, in which the use of whiskey or brandy is of some benefit, but these remedies should not be given indiscriminately nor in too large doses as a routine practice. Diffusible stimulants are most serviceable, in my opinion, in cyanosis, but, unlike Dr. Davis, I would give the aromatic spirits of ammonia. Oxygen is especially indicated when there is pulmonary obstruction. In my experience, it has been devoid of any good result when given simply because of the existing cyanosis. When there is widespread bronchitis or any other condition which interferes mechanically with hematosis, then oxygen is certainly beneficial, and it will prolong life many times, even if it cannot be saved.

**T. J. Pitner**, of Jacksonville: We have had three admirable papers on this very important subject, and it seems unnecessary to add anything to what has already been said and commented on. Only the importance of the sub-

ject would warrant any further remarks. First, as to the pathology of pneumonia. We hear it said now that it is no longer considered an inflammatory disease, and that it is not due to exposure. It seems to me that would tend to breed carelessness in our observations, and advice to our patients concerning exposure. Whilst we must acknowledge that the disease is due to a specific organism, we must remember that that organism works under certain condition, and in certain soil. These requirements are furnished in a certain way by a previous bronchitis, more particularly by influenza, exposure, the depression following taking cold, which are followed by the results of the invasion, the chill and the development of the toxemia. All these preliminary effects must be considered in our advice to old people, if we want to be thorough in carrying out the ideas of preventive medicine. Here is a field for us. One that is as important as the prevention of tuberculosis. We must tell our old friends in the months of February and March that they are in the immediate presence of their greatest enemies. The fact is that nearly every person who dies over sixty dies from pneumonia. It kills more people than all the other diseases combined. Our old people should know that, so that they will not boast of their vigorous youth and feel that they can do as they did when they were forty. We must give advice in such a way so that it will be regarded, and so that they will abandon occupations that are hazardous and that necessitate exposure. I am sure that in February and March more cases of pneumonia occur than in all the other months of the year. We must try to do all we can to avoid the conditions which favor the development of the disease.

The subject of treatment is so large that I cannot dwell upon it at this time. I wish, however, to express my profound disbelief in the statement that pneumonia is a self-limited disease, and that therefore we need not interfere actively or efficiently. I deny that proposition, as I believe that pneumonia is largely modified by medication. We know it is self-limited, but unfortunately death is the limit. Therefore, let us bestir ourselves, so as to reduce the mortality, as I believe we can.

**Archibald Church**, of Chicago: I have had the unfortunate experience on several occasions of being called to see an elderly individual who suddenly presented symptoms of mental disturbance, either in the form of mental depression, or even symptoms simulating an attack of senile dementia. That diagnosis has been made, although the symptoms existed but a short time. In a case I now have in mind the examination of the lungs showed that we were dealing with a condition of pneumonia in the aged, a pneumonia which was not attended by its usual distinctive features, and failed to direct attention to the lungs. Among the senile demented and demented generally, as well as in certain other varieties of mental disturbance, it is entirely devoid of its major characteristics. So much is this true, that those in charge of the insane learn by experience to look over their patients very carefully if slightly advanced in years, or if they suddenly present a depressed

mental condition. Those of us who have seen many cases of insanity can recall instances where marked forms of insanity were present, together with complete consolidation of one or more lobes of the lung, without the slightest cough, and without very much modification of temperature.

I am very glad indeed to have the suggestion from Dr. Babcock relative to rectal temperature in this connection, because the axillary or mouth temperatures are notoriously unreliable.

The point made by Dr. Reed that it is well to look over an old man when he gives up his usual occupation and goes to bed is a good one. We should look him over carefully, and this is also true of these cases that show sudden mental disturbances. We should always be particularly careful to examine the lungs.

**H. C. Howard**, of Champaign: I have been very much interested in the discussions on this disease which I have for years treated entirely as a germicidal disease, and have therefore based the treatment on germicidal processes. For years I have used inhalations of formalin in connection with chloroform, using it persistently and in all my cases of pneumonia with most happy results. This is particularly true of the severe cases. In a case of double pneumonia, I also gave formaldehyde of soda internally. I find that by giving one ounce of alcohol, one-half ounce of chloroform, and two ounces of a forty per cent solution of formalin, that nearly all cases of pneumonia are readily subdued in few days. Strychnine may be given in addition to this as a tonic. I use this combination as an inhalant, and during the last four years I have used it exclusively, discarding all other methods of treatment.

**S. E. Munson**, of Springfield: I would like to ask Dr. Davis if he has had any experience with carbonate of creosote or the application of antiphlogistine plasters to the chest. I have recently seen some cases treated that way, and would be glad to know what he thinks of it.

**Dr. Reed** (closing the discussion on his part): When the gentleman who spoke regarding the use of veratrum viride in pneumonia made his statement, I wrote down the experience of the medical profession today, and it does not agree with that of the gentleman from Peoria regarding the use of veratrum viride in the treatment of senile pneumonia. In preparing this subject, I will say that I never had met Dr. Babcock personally, and still in preparing this subject, knowing that he had given special attention to it, I wondered how my paper would strike him, so that it was with a great deal of satisfaction that I heard him say what he did.

**Dr. Davis** (closing the discussion): I had practically finished my paper when I stopped reading a moment ago, with the exception of a very brief paragraph devoted to the use of serum as now placed on the market. There are also a few paragraphs regarding the prophylactic treatment of pneumonia. I think you will all agree that today we are treating pneumonia more intelligently than ever before. We know more about the disease and more about the persons who have it, and are also accomplishing more in treatment. There is no doubt

at all that, so far as the mortality of itself is concerned, we are not to blame for it, unless we do not apply prophylactic measures, as we should. Like several other diseases, it is unquestionably communicated by the inhalation of noxious agents provocative of themselves; therefore, we should prevent, as far as possible, their dissemination, just as we advise in tuberculosis. During the time of treatment of a case of pneumonia proper care should be taken in preventing the indiscriminate expectoration and the collection of the sputum, just as in tuberculosis. It is also desirable to destroy the sputa and thoroughly cleanse the mouth with antiseptic washes during the illness and for some time afterward.

Above all things, the utmost care should be taken to maintain good ventilation in the room, not only during the time of the illness, but also during those months of the year when pneumonia is most prevalent. The public should be educated, if possible, as to the dangers of pneumonia, influenza, and other maladies of similar kind, and cautioned from living in crowded rooms, poorly ventilated rooms, and badly ventilated street cars, where the air is not only extremely offensive, but also deleterious. They should also be instructed in the matter of personal hygiene, especially during the months when rheumatic diseases are prevalent. The frequency of occurrence of a malady can be limited by prophylactic measures. This should be suggested to the public, in order to aid in enforcing prophylaxis.

As to treatment, it is very difficult indeed to estimate the value of any one drug in a disease which is naturally self-limited or of short duration, because many men are using different remedies in the treatment of this disease, the disease differs in different localities, and consequently we arrive at different conclusions. This makes it rather difficult to commend any one particular drug in all cases. Secondly, it is extremely difficult to determine the value of any one of this group of drugs in this particular malady, without much experience in its treatment. I did not have time in this very brief paper to touch upon the exceptional uses of drugs or their use in exceptional cases. But as to the employment of alcoholics, I administer alcoholics to those who are habitual users of alcohol, particularly if they have been using it excessively. I do that because it is the prevailing feeling in the profession that it is best to do so. I, myself, have a little doubt as to its actual utility, and I have been watching with much interest my cases of this kind, but, unfortunately, my observations have not been sufficiently extensive to warrant any positive conclusions.

I am opposed to the indiscriminate use of morphine. It must be used with the greatest care, and yet I have seen several cases of pneumonia that were apparently on the verge of dissolution, comatose, breathing with the greatest difficulty, deeply cyanosed, to whom a dose of morphine was given for the purpose of lessening the distress and discomfort, as the patient was about to die, who immediately after the administration of the morphine evinced great improvement and eventually got well.



Such cases lead us to use a drug, and in this particular instance it apparently did no harm, but its universal use should be condemned. In a few instances I have had all the symptoms relieved and have seen the patient recover when there was apparently no hope for them. In other cases, the administration of the morphine did no good at all. I simply mention these facts because of the difficulty of estimating the value of a drug, and especially morphine.

**Dr. Babcock:** Have you tried heroin?

**Dr. Davis:** Yes, but it is like morphine. I have also used carbonate of creosote quite frequently, but without any particular advantage. I have not used antiphlogistine myself, but have frequently seen it used in consultation practice. It certainly does no harm. It acts precisely like a poultice, so far as I can see.

I was very much interested in Dr. Reed's paper on senile pneumonia, and I wish to emphasize particularly what Dr. Babcock said, the necessity of taking the temperature by rectum. That point has frequently been impressed upon me most forcibly. I have found that, when the nurse reported the axillary or mouth temperature as normal or nearly normal, the rectal temperature would show a very distinct pyrexia.

## THE USE OF THE COLPEURYNTER IN OBSTETRIC PRACTICE.\*

BY JOSEPH B. DE LEE, M. D.

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The use of rubber bags in obstetrics cannot date further back than the time of the introduction of vulcanization of rubber, that is, about the middle of the last century.

In 1851 Carl Braun invented the colpeurynter (1). Chiari had, before this, used a pig's bladder, which he discarded because it decomposed in the vagina. Em. Stein had recommended the "tampon vessie" of Wellenbergh, in placenta previa (2).

Since this time many bags have been invented for use in the vagina, the cervix and the uterus. The colpeurynter was intended for the vagina, wherefore its name, but now it is almost always used in the uterus and its name should be changed to metreurynter.

Grenser modified the Braun instrument, making it simpler, cheaper, more durable and more useful. Garicl (3) made a bag for the vagina; Chassagy (4) for the vagina, cervix and uterus. Neither has attained general use.

In 1862 Barnes published his invention of the now well known fiddle shaped bags. They were to be used in the dilation of the cervix in many conditions, and to be held in place by the fingers. McLean modified this bag, placing two, side by side. In 1862, also, Tarnier invented his "dilatateur intrauterin," for the induction of premature labor. This consisted of a thin rubber bag at the end of a tube and carried inside the uterus by a sound. Others have modified this (5). The objections to this instrument are its fragility, and inefficiency. It is seldom used, but is important, however, in indicating the intrauterine use of bags.

In 1861 Madurovicz (6), assistant in the obstetric clinic of Vienna, in a case of placenta previa, accidentally allowed a Braun colpeurynter to slip into the uterus. He distended it with water and gently drew it through the cervix, aided by the uterine contractions. He thus dilated the cervix rapidly and so completely that he could turn and extract, saving both mother and child. He did not attempt to repeat the performance. In 1883 Schauta, having observed the intrauterine use of the colpeurynter in Spaeth's clinic, published the method (7).

The greatest impetus to the use of the colpeurynter was given by Maurer, who published, in 1887 (8), a case where he had put the bag in the uterus, and applied traction to the tube. In the same year Champetier de Ribes invented his cone shaped, inelastic balloon, which exceeds in size that of Braun and is stronger, being fortified with silk. It is used in the same manner and, to my mind, carries few, if any, advantages.

The intrauterine application of the Braun colpeurynter has practically displaced the other bags, with perhaps the exception of Barnes bags, and those of Champetier de Ribes, in a few instances and localities, and therefore this paper will be limited to the discussion of that procedure.

The insertion of the bag into the vagina is simple, more difficulty is experienced in placing it in the uterus. After thorough disinfection the bag is emptied of air, filled with sterile water, or lysol solution, emptied

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.



again, connected with a Davidson syringe, filled with solution, folded into as small a roll as possible, and then gently passed into the uterus, either inside or outside the membranes. While it is held in position by the fingers it is filled with a certain amount of fluid by means of the syringe, the exact amount injected depending on the case. The tube is clamped with an artery forceps, and traction may or may not be put upon it.

#### INDICATIONS FOR THE OPERATION.

1. For the induction of premature labor many means have been employed, whose great number proves that we lack one, meeting all the requirements of safety and efficiency. The method most in vogue is that of Krause, the insertion of bougies into the uterus. While this is a quite efficient method, it has the following disadvantages—it is often slow, many days sometimes elapsing till the uterus wakes up to regular action; it has the great danger of sepsis, the bougies remaining in the uterus for so long; in passing the bougie, the placenta may be separated, or perforated; they may cause pressure necrosis of the uterus, air embolism, and the bag of waters is likely to be ruptured, which is usually unwelcome.

We have in the intrauterine application of the colpeurynter a means for the induction of labor that is devoid of most all of the dangers. The bag is placed just above the internal os, outside the membranes and distended with ten ounces of water. If there is occasion for hurry, as in eclampsia, premature detachment of the placenta, hyperemesis gravidarum, traction of a pound or two is put on the tube. As a rule the pains come on within thirty minutes, depending on how near the patient is to term, and the bag is expelled in two to five hours, the labor comes into active progress. Rarely the pains cease when the bag is expelled, requiring further application of the instrument. If there is no hurry the bag may be left without traction, in which case the pains come on slower, requiring two to ten hours, perhaps longer.

I have used the bags thus successfully to induce labor in cases of contracted pelvis,

placenta previa, eclampsia, nephritis and hyperemesis. In two cases only had I reason to complain, in one of which the fault was not of the method. In one the pains ceased each time the bag was expelled, so that later the membranes had to be punctured, and in the other so much water was put into the bag that it displaced the head, resulting in a trunk presentation, necessitating version. No case had any sepsis, and none of the mothers died.

2. When there is any indication to hasten delivery, as in eclampsia, premature detachment of the normally implanted placenta, heart disease, etc., the colpeurynter is to be recommended. It evokes strong pains, softens the cervix, dilates it gently and firmly from above, all of which make delivery possible in a few hours. The colpeurynter has been used in the vagina for this purpose in normal labors, though this should not be generally done.

3. To prepare the parts for rapid delivery after symphysiotomy, or version. Where a difficult operative procedure in a primipara is anticipated, an unprepared cervix or vagina may thus be softened and stretched, so that the subsequent difficulty and injury are minimized. The delivery of the filled colpeurynter is then like that of the first twin, and the child meets with less resistance.

4. Stenosis and rigidity of the cervix, vagina and perineum are more formidable conditions, which the rubber bag may not be strong enough to overcome, but by its softening effect, plus the pains forcing it down like a fluid wedge, a surprising amount of dilation is effected.

5. For weak pains the colpeurynter was recommended by Naegele in 1863 (9). Cases of primarily weak pains are very rare; almost always some cause for the condition can be found which, removed, allows the labor to terminate rapidly. Rigidity of the cervix, vagina or perineum, abnormal adherence of the membranes over the lower uterine segment, too great distension of the uterus, pendulous abdomen, low insertion of the placenta and many other conditions may be cited as causes of weak pains, requiring

recognition and whose removal facilitates delivery. As a rule, when there is no cause for the weak pains, but an inherently lazy uterus, patience is all that is needed, but if an indication should arise for the rapid termination of labor, the uterus can be stimulated to action by no better method than the metreurynter.

6. In cases of so-called dry labor, the bags deserve more general application. Put inside the uterus, the colpeurynter replaces the bag of waters, the pains force this gentle, fluid wedge into the cervix, soften it, and thus procure a dilation that might otherwise have required hours or days.

7. In shoulder presentation, before complete dilation of the cervix, the rupture of the bag of waters is a most unwelcome occurrence, and this is also specially true of contracted pelvis, where the head is not engaged. The metreurynter is here of signal service, because it will substitute the bag of waters very satisfactorily. Braun is to be given the credit for this suggestion, which has not been used as much as it deserves. In shoulder cases, version is often impossible till the cervix is open, and to wait for same, would likely result in the shoulder becoming wedged into the excavation, rendering turning impossible. The metreurynter keeps the presenting part away from the pelvis, evoking pains, and dilates the parts, thus giving time for preparation, for summoning assistance and apparatus.

In 39 cases of version reported by Weindler, (*Centb. fur Gyn.*, 1902, S. 453), where the colpeurynter was used, the operation was done under complete dilatation of the cervix, and the condition and results were as favorable as when the bag of waters was intact.

8. When the cord prolapses with the head and the cervix is undilated, Ahlfeld recommends the funis as high up in the uterus as possible and then place a Barnes bag in the cervix, a procedure certainly worth remembering in those cases where the cord repeatedly falls down, after reposition. In such cases, too, the writer would suggest placing a rectal bag, or a stout rubber drainage tube alongside the cord to protect it from pressure.

9. During pregnancy the bags have decided usefulness. One may lift up a pregnant uterus that is causing hyperemesis, or replace a retroflexed incarcerated uterus, using water or mercury. It may here be mentioned that some women cannot tolerate the bag in the vagina long, it causing a profuse discharge, or even vaginitis—they seem to have a rubber idiosyncrasy.

10. Perhaps most valuable of all is the employment of the metreurynter in cases of placenta previa. Carl Braun recommended the bag to be inserted into the vagina in cases where the hemorrhage comes from the lower uterine segment. Madurowicz accidentally placed a colpeurynter in the cervix in a case of placenta previa, drew tentatively on the bag, dilated the cervix and could save mother and child, but he was not bold enough to follow up this advantage. To Maurer (10) is due indubitably the credit for introducing intrauterine colpeurynter, with traction, for placenta previa. To Duhrssen (11) is due the credit for placing the procedure on a scientific basis.

There is no doubt that the treatment of placenta previa needs improvement, especially in private practice. Futh (12) collected fifty cases in one German county. It showed a maternal mortality of 38 per cent and fetal of 80 per cent. Gillette, in a recent article (13), from statistics collected by a circular letter to prominent physicians of the United States, finds a maternal mortality of 15 1-3 per cent and fetal of 44 1-3 per cent. He therefore recommends Cesarean section for placenta previa, claiming that it shows less mortality for both mother and child—and in the latter he is right. Cesarean section in the hands of the men he quotes, Reynolds, Leopold et al., has almost no mortality, and placenta previa in the hands of the general practitioner has at least 15 per cent. What would be the mortality of Cesarean section in these same hands?

We have, happily, in the metreurynter a means that in the practice of the general practitioner is capable of reducing the deaths from placenta previa to a low figure, and will save a large number of infants. In the hands of the skilful accoucheur the same method

will save all the mothers and the large majority of the babies (14) Kustner (15) says that "metreuryasis is capable of reducing the maternal mortality to a minimum and likewise that of the children." See also Rosenthal (16). Ahlfeld recommends the method; also, Jewett (18).

Recent writers in America do not give the method the attention it deserves. Hirst makes no mention of it, nor did Fry, of Washington, in a paper he recently read before the Amer. Gyn. Assn. at Chicago, yet the colpeurynter is perhaps the most valuable addition to the obstetric armamentarium of the last century.

The metreurynter is not to be used in all cases of placenta previa. If the cervix is completely dilated, delivery may at once be accomplished by version and extraction, or the forceps. When the cervix is closed, admitting only one or two fingers, the bag is indicated, and it here comes into competition with Braxton Hick's version and accouchement force. It is to be preferred above both, for the version offers less chance to the infant and the forced delivery in placenta previa offers more danger to the mother. The metreurynter may be used to inaugurate labor, or to hasten one already begun, or to stop hemorrhage temporarily till the woman can be gotten into such condition that she might stand a more heroic operation (18). The method is simple. The preparations are the same as for any grave vaginal operation, the membranes are ruptured and the bag is placed on the fetal surface of the placenta. It is filled with water, ten to twenty ounces being used, the tube clamped and traction put on the same by means of a weight hanging over the foot of the bed. The writer prefers to make the traction himself, by means of the hand, as then he may graduate it, and allow some relaxation at intervals to permit blood to seek the cervix. An anemic cervix does not dilate as well, and constant traction might keep the blood out of the tissues.

This procedure stops the hemorrhage at once, if properly carried out. In placing the bag one must see that the placenta is not

rolled up under it, as then internal hemorrhage might occur. This is very rare and easily avoidable.

After a few minutes to an hour pains begin, and aiding the traction, force the bag down into the cervix, dilating it gently from within, imitating the bag of waters perfectly. In from two to eight hours the bag is expelled through the cervix. One should watch the patient closely for signs that the bag has passed into the vagina, and all preparations should have been made for delivery, or for the insertion of a larger bag, if the cervix is still unprepared for the former. One should not allow the bag to rest in the vagina, as an enormous amount of blood may accumulate behind it. The sharper pains, the bearing down efforts, the advancement of the tube, show the passing of the bag into the vagina, it should be drawn on, delivered, filled, through the vulva, and further procedure instituted at once. Sometimes the head follows the colpeurynter into the vagina and then the labor proceeds as a normal one, if not, forceps may be used; if the head is still high up, version, and here let me warn to wait with the extraction. Slow delivery, as Schroeder recommends, till the parts are well prepared for the necessary great dilation.

The writer cannot urge too heartily the wider employment of this simple procedure. It stops the hemorrhage to a certainty by compressing the placenta against the open sinuses, strengthens the pains, dilates the cervix, preserves the child from asphyxia, and gives time for the patient to recover from the shock of an initial, severe loss of blood, for the injection of saline solution, for summoning counsel and assistance. The general and early practice of this measure will, I am sure, reduce the maternal and infant mortality, before quoted, almost to nothing.

(1) See Zeitsch. der k. k. Gesell. d. Aerzte in Wien, VII. Jahr. Bd. 11, 1851, p. 527; also Chiari, Braun, und Spaeth, Klinik der Geb. I Lief. p. 125.

(2) Reflexions sur l'implantation de l'arrièrefaix sur le col de la matrice. A la Haye, 1849, 8. Cf. Kilian, Rheinischer Monatschr. f. Prak. Aerzte, Jan., 1850, S. I.



- (3) Charpentier, *Prat. des Acc.* II, p. 460.
- (4) *Ibid.*
- (5) Winekler, Stehberger, Greder, see Biermer. *Der Colpeurynter*. Wiesbaden, 1899.
- (6) *Centb. f. Gyn.*, 1888, p. 665.
- (7) *Centb. f. die gesammte Therapie*, 1883, Heft I.
- (8) *Centb. f. Gyn.*, 1887, p. 393.
- (9) Naegele, *Geburtshilfe*, 1863, Seite, 476.
- (10) *Centb. f. Gyn.*, 1887, S. 393.
- (11) *Deutsche Med. Woch.*, 1894, Nr. 19.
- (12) *Centb. f. Gyn.* 1896, S. 918.
- (13) *Jour. Amer. Med. Assn.*, 1901, p. 495.
- (14) Duhrssen, l. e. six cases, six mothers and five children living.
- (15) *Discussion of Placenta Previa*, in the Leipzig Gyn. Congress.
- (16) Enges Beeken und Colp. *Arch. f. Gyn. Bd.*, 45.
- (17) *Practice of Obst.*, p. 504.
- (18) DeLee, *Treatment of Placenta Previa*, *Chicago Clin. Review*, Aug., 1900.

### DEEP TRANSVERSE ARREST OF THE HEAD AS AN INDICATION FOR FORCEPS.\*

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American obstetrical literature is strangely silent regarding this not infrequent position of the foetal head during labor. Since the time of Hodge, who described it quite fully, no author excepting Dorland has considered it worthy of even moderate attention, although in a few instances it received casual attention in text books as a variety of occipito-posterior position, under which it is described and dismissed in a few lines. On account of the definite character of this position, its frequency, and pronounced effect upon labor, it seems entitled to more especial consideration.

Its obstetrical dignity is exhibited by the statistics of Ahlfeld, who found thirty-eight

Read at the 52d Annual Meeting, Quincy, May 20, 1902.

eases in three thousand labors (Abt I., 26), which is only a slightly less frequency than all occipito-posterior positions (1.5 per cent of all vertex cases).

Torggler (1888, Prague), reports thirty-four cases, which represented a frequency of 1.5 per cent in his service.

In the last thirty-six hundred labors in the Chicago Lying-In Hospital, the condition has been recognized thirty-four times, but owing to the practice prevailing in this institution of making very few internal examinations, it is probable that some cases of deep transverse arrest which spontaneously rotated, have escaped notice and have been regarded simply as unusually slow and tedious labors, but even so the number amounts to about 97 per cent of all cases reported.

When the head is thus "impacted," it will be found low down in the pelvis with the sagittal suture parallel with the transverse diameter of the inlet and no tendency toward anterior rotation of the occiput. The head is slightly extended, the chin removed from the sternum, the fontanelles being at about the same level, and the labor at a standstill, owing to a definite interruption in the rotating mechanism. This deflection marks the beginning of the series of abnormal presentations which are characterized by varying degrees of extension.

Of the thirty-eight cases in Ahlfeld's service, twenty-seven were in I parae. In Torggler's series the condition appeared in I parae five times as often as in multiparae, and in both series, according to the figures of Munch, 81.61 per cent of the cases happened in I parae.

The same author believes that the preponderance of cases in this class is due to the early descent of the head into the pelvis during the last three or four weeks of pregnancy, and that during this period it remains in a more or less transverse, and probably deflexed condition until the onset of labor.

When labor begins, the head has reached a point where the factors which guide to occiput forward, work at a disadvantage, the slight degree of deflexion being sufficient not only to disturb the mechanism of rota-

tion, but a longer diameter—the suboccipito-frontal, must now be acted upon by the expelling forces. The head has only a short advance to make before reaching the pelvic floor and as rotation must be accompanied by some advance of the head, the most that can be secured is rotation of the occiput into one of the oblique diameters where the labor stands still.

It is more probable that in I parae the soft parts grasp the head much more closely, and yield less readily to the powers of rotation, while coincidentally the powers of rotation naturally undeveloped are more quickly exhausted, so that both the powers and the resistances combine to prevent the forward rotation of the occiput.

This unusual frequency among I parae is not borne out in the series of cases taken from the statistics of the Chicago Lying-In Hospital. Here nineteen cases were found among women who had borne from two to eight children, and only fifteen in I parae. But the impoverished conditions in which these people live favor defective innervation, weak pains, contracted pelvis, and other factors of etiological importance. It is possible that these women had attained the acme of their physical development at the time of marriage, and from then on, environment, lack of suitable nutrition, and excessive work, in addition to the care and nursing of children, so weaken the nervous and muscular systems that the danger of weak pains, inertia uteri, and insufficient action of the abdominal muscles, increases with each pregnancy, and thereby the importance of any other etiological factor is greatly intensified.

In flat pelvises of high deg. the head does not enter at all without interference, but in flat pelvises of moderate deg. the head frequently engages in the transverse diameter with large fontanelle on same, or lower level than the small, because of the shorter bi-temporal diameter, and anterior rotation is delayed until the head reaches the small pelvis where the proportionately small sagittal diameter, together with the deflection of the foetal head, prevents rotation and the head

reaches the pelvic floor in the transverse and maintains this position.

The generally contracted pelvis also furnishes a certain proportion of the cases (10.5 per cent), and Zweifel reports a case where over-development of the frontal bone caused it to become incarcerated in the obturator foramen, and rendered forward rotation impossible.

Other conditions may arise, such as the prolapse of an arm between the head and the anterior pelvic wall, which mechanically prevent the rotation. It is very interesting to note that 47 per cent of Ahlfeld's cases occurred in pelvises that were too large, either actually or relatively. In these cases the necessity of obedience to Pajot's law of accommodation which largely controls the anterior rotation of the occiput, is absent and the factors which generally direct the occiput forward cannot act on account of the relative disproportion between head and pelvis, so that the head remains transverse.

Only a small hindrance is necessary to prevent rotation where the mechanism once becomes imperfect, thus ankylosis of coccyx, a protruding sacrum, or exostoses of symphysis or sacrum, may easily produce this result. In the "too wide" pelvis the bag of waters may suddenly rupture under the stress of powerful pains and the head be forced thereby into the pelvis in a transverse position.

In another class of cases the head and pelvis may be normal and the powers of labor so weak that the "turning mechanism" does not functionate and the occiput does not rotate. The head may descend with occiput anterior or posterior, and rotation occur into the transverse where the process stops.

By disturbing the flexion of the head, and by favoring engagement in anomalous positions, pendulous abdomen must be regarded as causative also. Where the foetal head is abnormally long antero-posteriorly (dolicocephalus) the danger of impaction is greater because the two arms of the lever are nearly equal in length and flexion does not occur.

The diagnosis is readily made by vaginal examination, the head is found on the perineum or a little beyond the midplane, the sagittal suture is transverse, the fontanelles palpable at about the same level on opposite sides of the pelvis, and the progress of the labor arrested. For the mother and child danger arises from the great prolongation of the labor, the occasional absolute cessation of the pains besides the consequent evils of exhaustion, rupture of uterus, sepsis, post-partum hemorrhage, vesico-vaginal and recto-vaginal fistula, necrosis of maternal tissues, or of foetal scalp and cranium.

To be sure, these cases usually terminate favorably if given time enough, but the condition of the child or of the mother may necessitate early intervention. The occiput may rotate anteriorly and the case terminate normally, or it may rotate into the hollow of the sacrum and remain as an occipito-post position, or greater deflexion may occur, the large fontanelle sinking lower than the small one, and taking the line of direction produces a forehead presentation; or, again, if the pubic arch is large enough, the vagina and the perineum distensible and the impelling force strong, the head may be delivered in the transverse position, as in four of Ahlfeld's cases, one of Torggler's and one of my own.

The treatment varies with the conditions in each case. Where no necessity for immediate delivery exists, the woman is placed upon the side toward which the occiput points for an hour or so; this permits the occiput to sink deeper into the pelvis, flexion is facilitated, a smaller diameter (the sub-occipito-breg) is brought into relation with the plane of the pelvic strait, rotation frequently occurs, and the case terminates spontaneously.

If this fails, two fingers (Tarnier) or the half hand may be carried in behind the posterior parietal bone and an attempt made to assist the forward rotation, but this maneuver is more apt to succeed in the cases due to large pelvis, or small head. If this fails, pressure may be made upon the symphysis upward during a pain to secure flexion (Hodge). The vis-a-tergo may be increased

in selected cases by the Kristellar expression.

The average duration of the second stage in Torggler's series was two hours, and in the Lying-In Hospital series about four hours, as the blades are only applied in this service under very strict indications. In danger threatening mother or child, the labor should be immediately terminated with the forceps, but otherwise interference should be delayed until it is evident that the head will not rotate spontaneously. If no progress occurs within two and one-half hours after complete dilation of the os, the forceps may be applied, and indeed in a majority of cases the forceps are indicated to complete the delivery.

From a study of cases it is probable that of all instances where forceps are applied under strict indication, the head is found in deep transverse arrest in approximately 35 per cent.

Twenty-four of Ahlfeld's cases were terminated with the forceps, and fourteen rotated spontaneously, danger to child constituting the most frequent indication for forceps in this series.

In the Lying-In Hospital service, forceps were applied twenty-four times, and in ten cases rotation occurred without artificial assistance. In this service material conditions most frequently furnished the indication for interference. A slight traction many times will start the rotation and the labor easily terminates.

It was in this class of cases that the vectis formerly found its greatest utility.

In the peculiar application of the forceps lies the necessity for accurate diagnosis. The forceps blades are constructed for application to the sides of the head, but if so applied in "deep transverse arrest," they will lie in the antero-posterior diameter of the pelvis, which is not possible for forceps with a pronounced pelvic curve, neither can the blades lie in the sides of the pelvis because the foetal head would be grasped in antero-posterior diameter, which is a bad position for the head and an unfavorable one for the forceps. Hence compromise is necessary, and the blades must be applied in one of



the oblique diameters with the pelvic curve toward the occiput. If the occiput lies to the woman's left, the forceps should be applied in the left oblique, i. e., a line passing between the blades lies in the left oblique diameter of the pelvis; the left blade resting on the anterior malar bone and the right on the posterior parietal protuberance. When the occiput points to the right, the forceps lie in the right oblique, etc.

The application presents some difficulties. The patient being in dorsal position with elevated hips on the table, the left blade is passed along the palmer surface of the right hand into the hollow of the sacrum behind the head and allowed to remain there if occiput points to the left, while the right blade is introduced into the hollow of the sacrum and carefully rotated under guidance of fingers, over the face of the child to the anterior malar bone.

If occiput lies to the right, the left blade is rotated over the anterior malar bone before the right blade is introduced. Thus the head is grasped in large diameter, care must be used to avoid too much compression on the head during traction, hence a finger or a towel should be placed between the handles. Two objects must be kept in view—rotation and extraction. The occiput should not be rotated forward directly for fear of lacerating the vaginal walls, but traction and rotation must be simultaneous, and about in the proportion of two of traction to one of rotation. Occasionally, however, the vagina will be torn in difficult cases in spite of every precaution.

After each traction the handles should be relaxed and the sutures and fontanelles examined to note progress. Readjustment of the blades should be made as often as necessary until they lie in the sides of the pelvis and grasp the foetal head. After rotation occurs the blades may be removed, and if the pains are strong, nature may be allowed to terminate the case, assisted possibly by Ritgen's maneuver.

The axis traction forceps may be applied directly to the pelvis irrespective of the position of the head, rotation occurs without

interruption from the blades, and the results are generally satisfactory.

The use of the axis traction instrument for all cases following Milne-Murray is the rule in Scotland and Dublin, and the practice in France.

#### TO SUMMARIZE.

Deep transverse arrest of the head is a relatively common complication in labor.

The diagnosis is easily made from the position of the sagittal suture, and the fontanelles.

The normal termination of the case cannot be waited for in most instances, but forceps should be applied as soon as it is evident that rotation will not occur spontaneously.

The blades should be applied in that pelvic oblique diameter toward which the occiput lies.

Location of the occiput must be determined before the blades are applied.

Traction and rotation must be simultaneous.

#### Discussion on the Papers of Drs. Reed, De Lee, Davis and Bacon.

(The paper of C. S. Bacon appeared in our November issue. The paper of Effa V. Davis will appear later.)

**Charles B. Brown, of Sycamore:** Mr. President—With reference to the use of the rubber bag, in the first place, the country obstetrician does not find it very practical because he seldom has use for it. One may carry around these bags with him for six months or a year, and by that time they would not be any good.

There is one particular point I wish to make, and that is, I would not dare to wait in a case of eclampsia for dilation of the cervix with a rubber bag. I should very much prefer to use my hand or my fingers, as it would be more expeditious. I should be afraid my patient would die.

**O. B. Will, of Peoria:** I do not rise for the purpose of discussing the papers, but I would like to ask Dr. De Lee a question, namely, whether, in his experience, he recalls any accident from the bursting of a bag. A few years ago I presented to this Society the history of a case occurring in the practice of a colleague, which was the subject subsequently of a Coroner's inquest, and for some time he had hanging over his head a suit for malpractice. In that case the bag burst, air entered the uterus, air embolism ensued, resulting in the death of the patient, and while it was considered professional in our local Society, it was, of course, looked upon as one of those unavoidable accidents that will occur. It is wise for us to understand that such a thing is at least possible, and how frequently it occurs I do not know. I may say for your benefit that in the instance referred to the

Coroner's jury undertook to advise the profession to abandon the use of the bag, because it was a dangerous instrument.

**Everett J. Brown, of Decatur:** This is a most interesting discussion to the general practitioner. We who live in small towns see a great many emergency obstetric cases that are badly treated, and I have had a great many cases related to me from time to time by country physicians which, if they had been properly prepared to meet the emergencies, the patients would still be living.

I recall two cases of eclampsia which had been treated badly for hours. I remember one patient who was unconscious for ten hours without any dilatation of the cervix, without any attempt having been made to deliver the woman or without any chloroform having been given. In that case I used a Barnes bag and delivered the child, but it was too late to save the life of either the patient or the child.

Recently I had an experience in my own practice in which I saw the beneficial effects of the colpeurynter or similar bag for dilating the cervix. The patient was threatened with eclampsia; she was eight months' advanced in pregnancy; she had universal anasarca, and was beginning to have uremic symptoms, so that I feared eclampsia. I called in Dr. De Lee in consultation, and in that case I saw the beneficial effect of rapid delivery. The child was saved. The child is now five months old and is doing nicely. Undoubtedly the prompt use of the colpeurynter in that case prevented eclampsia. There is no doubt the patient would have had eclampsia within a few days. She was beginning to have difficult breathing; she began to have specks before the eyes, and, in fact, all of the prodromal symptoms indicative of eclampsia. I have no doubt that in the hands of the ordinary practitioner the case would have been allowed to go on to normal delivery, and undoubtedly eclampsia would have ensued, and, as we know, eclampsia is generally followed in many instances by death. I prefer the use of the colpeurynter in many cases to the Barnes bag. I like the colpeurynter better than the inelastic tube, although most obstetricians use the inelastic rubber canvas bag. They use the ordinary piston syringe for inflating the French bag, which I do not like as well as the Davidson syringe, such as is used by Dr. De Lee. A great many cases of atony of the uterus can be assisted materially by the use of these bags.

With reference to the paper of Dr. Bacon, I have recently learned of a case of post-partum hemorrhage that was recovering, and the woman doing nicely, according to the statement of the physician. He went out to unhitch his horse, and while doing so the woman fainted. He left half an hour before the child was delivered. He left the woman too soon. He dilated the uterus with his hand, and it seemed to contract nicely.

I have wondered if the use of adrenalin would not be a prophylactic in cases of post-partum hemorrhage. I have seen good results from its use in hemorrhage at the climacteric, and at puberty, one or two doses having been given internally. Therefore, I have thought it

would be a good prophylactic in cases of expected post-partum hemorrhage.

**Lucy Waite, of Chicago:** Dr. Davis spoke of and described the German method of delivery, and in this connection I wish to say that while I was in Vienna I had the opportunity of seeing many deliveries in the maternity there. Normal cases are delivered by midwives, and if a midwife feels that she cannot deliver a child without tearing the perineum it is her duty to hand the case over to the head midwife. I have seen the head midwife deliver a child's head over the perineum as thin as tissue paper, so to speak, without tearing it. The head midwife sends for a physician if she feels she cannot bring about delivery in a given case, and she is so skillful that it is considered a breach of etiquette on the part of the physician to undertake to deliver a child in her presence, but if she sends for a physician he must deliver.

**Charles S. Bacon, of Chicago:** We ought mutually to attack and have an opportunity to defend those facts. I would like to take this opportunity to commend very much the paper of Dr. De Lee, and while I have no doubt that the use of the bag is of great value, still there are one or two points of difference that might be brought out. In the induction of labor by the use of the bag there is a little danger, particularly in cases of heart disease, of kidney disease, where there is a good deal of edema, and where the heart is secondarily perhaps affected. The introduction of the bag in such cases without rupture of the membranes increases the distress of the patient, and I do not think the use of the bag in those instances is desirable. If it is used, it should be employed after the rupture of the membranes, and should be placed inside of the cavity of the membranes, instead of being placed in the cervix, thus increasing the distention of the uterus. That would be the case in hydramnion or conditions of over-distention of the uterus where the bag is used.

Attention should be called to the danger of sterilization of the bag. It is difficult to sterilize, and only the best bags that will stand boiling should be used. The majority of bags do not stand much boiling, and, of course, the danger of infection from the bag is very decided.

I was a little surprised at one statement made by Dr. De Lee, namely, the idiosyncrasy of patients against a soft rubber bag in the vagina, after wearing it for some days. I am inclined to think that this idiosyncrasy lies largely in the material which will so easily become infected and contaminated as a rubber bag will. Soft rubber is a thing which is of doubtful utility in the vagina, and I do not believe there is any idiosyncrasy on the part of patients against rubber, but simply the contamination and infection which contraindicate the use of the rubber bag in such cases.

In regard to the paper of Dr. Davis, it was very interesting indeed. I should like to say that it is practically immaterial whether a patient is delivered on the side or back, provided, when the patient is in the dorsal position the hips are so much elevated that one gets control over the perineum. The danger of delivery in the dorsal position is that the hips come down under the bed, but if they are elevated to



control flexion of the head as well it is really a much nicer position to deliver a patient in the ordinary cases.

With reference to lacerations, a vaginal tear cannot be separated from the question of perineal tears. So the statistics or cases that Dr. Davis gave us were somewhat disappointing, because it is rather difficult to conceive of a case of perineal tear without a vaginal tear, and I assume that there were no vaginal tears because one or two stitches were used. As a matter of fact, many physicians neglect to look for vaginal tears, which are really of more importance than perineal tears, and, of course, are generally found in connection with them. There is one point I would like to bring out prominently, and that is, when the head is down at the outlet pressing on the perineum, if we find a little hemorrhage taking place, then we know there is the beginning of a vaginal tear, and we know we shall have a repair to make, and if we have got a case of that kind, with a firm vulva that is not yielding, it is a good case for episiotomy. The vaginal tear must be repaired, and such a case is suitable for this operation.

**Joseph B. De Lee, of Chicago:** Before replying to this discussion on my own paper, I would like to mention a few points with reference to the other papers that have been presented.

I must confess that I have not been so successful in protecting the perineum as Dr. Davis has. I have tried pretty nearly all the methods she has described in her paper, and I have found on careful inspection of the vagina and perineum after labor a number of tears in many instances. I have quizzed various of my confreres, and find that their experience is the same. From careful observation of their cases post-partum there are usually found a large number of tears. What do we mean by a tear? Some practitioners have decided that a tear is not strictly a perineal tear until it goes through the anus up into the rectum. My percentage of such tears has been practically zero. If we mean the fourchette is torn, and if there is a wound deep enough to put the finger in, it is a tear. When it is larger than that or large enough to introduce my finger I repair it. Judged by that standard, I have had a number of tears, perhaps sixty per cent, in primipara, which would admit my finger that far (illustrating). One stitch will bring such a tear together and make a good perineum, although the perineum was not endangered before.

Vaginal tears frequently pass unnoticed, as Dr. Bacon has said. The vulva must be opened wide to see a vaginal tear. I have seen a tear extend down to the rectum with the sides of the perineal body retracted without laceration of the skin fourchette. Those tears are the hardest ones to sew up. I cut the skin down to the anus and make my repair in the usual manner. I have seen such tears in the practice of consultants go unnoticed, and so I am skeptical with regard to any man delivering more than twenty-five cases without a tear. I do not believe that a hundred primipara cases can be delivered by any man, no matter how skillful, without some tears that urgently require the use of sutures for their repair. I have seen normal perineum where labor has been precipitated before I got

there. Other perineums, which do not give any evidence of tearing, tear easily. The personal element in the saving of the perineum from laceration is not as strong as is generally believed.

Regarding the maneuver in placing the hand in the rectum and bringing the head over the perineum, I have seen fissure of the rectum and anus take place as a result. I have seen my finger covered with blood, so I have given it up.

Regarding episiotomy, I agree with Dr. Bacon. With the delivery of the head you will notice a little blood appearing at the vulva, because the head packs the vagina tight, and the vaginal tear may be slight. If the vagina begins to tear before the head has come out or is about half way, how can the head come through without tearing it more? As long as it begins to tear before the head presents no human skill can prevent it from tearing. We can, however, limit the tear, or direct the tear so that it shall not run down into the anus. We can take a scissors and cut so that the tear is directed at the side of the anus. I have in some cases cut three-quarters to an inch and a half below the level of the anus. What kind of manipulation could have saved the anus if the tear had gone straight through? So much for episiotomy.

In answer to Dr. Bacon, I will say that Dr. Bacon and I disagree in regard to the use of the uterine tampon. He does not use it as much as I do. I believe that the introduction of Duhrssen, of the tamponnade of the uterus, is very often the method of treatment for post-partum hemorrhages. The number of women who die from post-partum hemorrhages is small; but the number of women who remain invalids for a long time as the result of post-partum hemorrhages is large. You will remember that Dr. Dock said this morning in his address that one of the causes of pernicious anemia is a severe hemorrhage during labor. It is not a frequent cause, it is true, but one of the causes. Since pernicious anemia occurs quite often in puerperal cases, since it is one of the causes, it is an important factor. I have had a patient under observation who had a severe hemorrhage eight years ago. These patients should lose as little blood as possible. We do not know whether the use of massage and ice in the uterus are going to be successful or not. If we are sure they are going to be we should take our chances of a little blood. When I have a hemorrhage post-partum, whether from a tear or from the interior of the uterus, if the hemorrhage promises at the start to be serious, I tampon the uterus. If it promises to be a mild hemorrhage, I resort to some of the milder methods.

In reply to the remarks on my own paper, Dr. Brown, of Sycamore, said that these rubber bags were not suitable for the country practitioner; they were not good; that they would wear out or, in the course of time, dry out and become useless. If the Doctor will take any of these rubber bags and put them in a saturated solution of boracic acid, at the end of a year he will find them in as good condition as they were before. I have a colpeurynter that I have used for a year and a half, and every time I am called to a case I blow it up and manipulate it. I do not keep them in boracic acid all of the time,



because I use them so often. If I did not use them frequently, I would keep them in boracic acid solution.

In regard to eclampsia, rubber bag dilatation of the cervix is considered by some too slow. Some obstetricians say that we should not deliver so fast in eclampsia, as great harm is done both the mother and babe in the rapid dilatation of the cervix and rapid extraction of the child. A number of deaths in cases of eclampsia have been produced in that manner.

With regard to air embolism, I was glad to hear the case reported by Dr. Will. The danger from air embolism is obviated if the instructions given in the paper are followed. Five or six times in my practice I have had the rubber bag break without the least bit of trouble, and when this is the case I use another one.

As to the use of adrenalin, suggested by Dr. Brown, of Decatur, to my knowledge it has not yet been used. I would hesitate to use it in the uterus as a local application on account of the difficulty of obtaining a sterile preparation.

In cases of hemophilia, referred to by Dr. Bacon, where death is almost inevitable, I have found the use of gauze soaked in gelatine (two per cent solution), the gauze dipped in gelatine and packed in the uterus, was very beneficial in one case with a hemorrhagic diathesis, and this patient responded to no other method of treatment. I have used calcium chloride and gelatine by mouth in hemophiliac cases, and can recommend it.

With reference to heart disease as a contraindication to the use of the rubber bag, when we come to introduce a rubber bag in a case of heart disease I would recommend under such circumstances a combination of rupture of the bag of waters and the introduction of a rubber bag.

Regarding sterilization of the rubber bag, it is a simple matter. The bag should be thoroughly boiled in plain water for half an hour.

As to patients having an idiosyncrasy for rubber, I dislike the assumption that I am a superficial observer. I have used rubber bags in some cases without this idiosyncrasy being manifested toward rubber. The same method of treatment in other patients has produced more discharge and irritation, so that the bags have had to be removed every day or so. Other patients were enabled to carry the bags for days without reaction. There are women, however, who cannot tolerate rubber bags, because they produce pain, distress, and discharge in a few hours or a day.

**Dr. Reed** (closing the discussion on his part): I have very few words to say. In regard to Dr. Bacon's paper, Dr. De Lee has covered the subject of the Dührssen method of tamponnade of the uterus so well that I have very little to say in regard to it, other than to have used it myself successfully in many cases, and can heartily endorse the method.

In regard to the use of styptics, which Dr. Bacon mentioned, I cannot see any advantage from their use, and I can see a great disadvantage which might result from their use. The formation of various coagula and various other conditions would, I think, make it impossible to

use styptics from the standpoint of safety. I believe that the majority of the profession are right in having given up almost entirely the use of styptics in the uterus. I believe that we have in the tamponnade of Dührssen a safe and almost universally efficient method of stopping uterine hemorrhage, which can be always done. The practice which formerly prevailed of going to a case of labor with only a package of gauze is absurd. Every case of labor should be regarded as a possible surgical emergency, and treated as such.

In regard to the maneuver mentioned by Dr. Davis for the protection of the perineum, I would suggest that if she persists in employing that method that she use Ayer's cot introduced into the rectum at the time of labor, which prevents contamination of the finger, and, at the same time, supports the rectal wall and prevents rupture from taking place.

I can also endorse fully Dr. De Lee's method of using the colpeurynter in the great majority of cases. I believe it is safe, efficient and satisfactory. The only objection I have found to it has been the time which is required in many instances before its successful operation.

In closing, I would say in regard to my own paper that I believe the great majority of deep cases of transverse arrest in primipara must, of necessity, require the use of the forceps, while for the delivery of multipara, they are not always necessary.

**Dr. Davis** (closing the discussion on her part): With reference to what has been said about the extraction of the placenta, I recall several cases where its delivery was effected practically without assistance. Physicians are quite often called upon to extract a placenta that has been left for three or four hours after the delivery of the child. I do not believe in the violent use of the Crede method or in the use of massage immediately to irritate the uterus with a view of expelling its contents, as I believe we will lose more blood by that method. One should judiciously wait an hour or more, carefully watching the uterus to see whether the placenta has descended or not, and usually after waiting an hour a gentle Crede will expel a normal placenta without very much loss of blood.

Regarding hemorrhages, I prefer a patient who has a free hemorrhage rather than one who has had a bad tear of the perineum. As to vaginal tears, I meant superficial ones. I did not report tears extending high up in the vagina. If the lacerations are not high, I let them go. If there is any laceration of the perineal floor or any laceration of the levator ani, extending to the side, those are considered perineal tears in my work and are sewed up. Some of these cases have no tear of the skin; they are internal tears, tears of the perineal tissue. I consider a half inch tear in the vagina (and I can say that from careful observation) sufficiently large to sew up. There is a great deal in the art of applying the measures I have suggested. One who has not delivered and is delivering a large number of primiparae will lose the art. When in the hospital I had most of these methods brought to my attention. They are practical,

and I find, much to my delight, that I can prevent many tears now that I was unable to obviate previously.

With reference to the remarks of Dr. Waite, I am familiar with the work done in the maternities abroad. In delivering primiparae constantly, if we follow the laws which I have suggested, we would do much better and more effective work.

With reference to the performance of episiotomy, how are we to know whether a nick in the perineum which causes a drop of blood calls for an episiotomy or not? It seems to me it is largely a matter of judgment, and as the tears are not very large, and episiotomy requires the use of two or three stitches on either side, it is practically of no consequence to sew up a tear rather than produce one. I do not wish to be understood, however, as decrying or belittling the importance of episiotomy in selected cases; but I think I am able to prevent the use of episiotomy more and more by following the methods or laws I have outlined.

In regard to blood appearing at the vulva as a sign that the perineum is going to tear, and it will be necessary to perform episiotomy, blood will appear at the vulva where a sharp bend of the head exists. You will have a little blood which may be mistaken for the sign Dr. Bacon refers to, but this should not be considered an indication for episiotomy. A little blood manifesting itself at the vulva is not a positive sign for episiotomy.

**Dr. Bacon** (closing the discussion): I would not consume any more of the time of the Society were it not for the fact that the chief point of my paper has been missed. I advised a combination of external massage to stimulate the uterus and the use of good, large doses of ergotol, which can be injected under the skin, or the aseptic ergot of Parke, Davis & Co., with the use of long-continued, very hot douches. I place a good deal of reliance on the hot douche, and insist that the technique must be properly carried out. In order to give a long douche, to give it instantly the hemorrhage begins, one should be prepared beforehand. It is necessary to have a syringe hung up and an unlimited supply of hot water. This does not mean two or three gallons of water, but it means an unlimited supply of hot water, which must be prepared in all cases of suspected hemorrhage, and one should see to it that it is possible to get this in any case. The douche can be given by taking the rubber sheet which covers the bed, pulling it a little to the edge of the bed, turning up the edges so as to make a trough of it, bringing the patient in such a position so that her hips extend half over the bed, supporting her in this position by having a nurse or someone sit by her side. With the patient in this position the syringe and the injection are ready, so that the latter can be given in from ten or fifteen seconds after the commencement of the hemorrhage. This is kept up until the hemorrhage stops permanently. The hot water stimulates contraction of the uterus and blood vessels. I believe it will stop any hemorrhage that can be stopped by packing, and I am not sure but it will stop a hemorrhage that packing fails to stop. Packing simply stimulates the uterus to

contraction; it does not plug the vessels alone unless the uterus is contracted. Furthermore the uterus may express the packing, and then there is no longer a stimulant in the uterus, the hemorrhage may continue in spite of gauze in a case of hemorrhagic diathesis. I have seen four deaths from hemorrhage where the uterus had been packed by physicians who understood how to pack. In spite of the fact that the packing was repeated two or three times, the hemorrhage continued until the patient died. One case, after three or four packings, in Professor Chrobak's clinic, died shortly after the packing was removed. I have known of three other deaths. Dührssen has removed the uterus on account of packing not controlling the hemorrhage. So packing is not always efficient. Furthermore, there is danger of infection from it, and for that reason I prefer the douche, given right and in sufficient quantity, to the packing.

## THE ACCIDENTS OF ANESTHESIA. THEIR PREVENTION AND TREATMENT.\*

BY DANIEL N. EISENDRATH, M. D., CHICAGO.

It would seem as though the subject of anesthetics especially ether and chloroform had been so thoroughly discussed in the last 20 years both in Europe and America as to leave but little to be said. My only reason for bringing it up at the present time is that our more exact methods of clinical observation and of experimental investigation have given us far more accurate knowledge of their action. Antisepsis, anesthesia and hemostasis have been the foundation stones upon which modern surgery has been erected. Many anesthetics or methods of anesthesia have been proposed from time to time, but the two pioneers ether and chloroform still hold the first place. Ethyl chloride and Schleich's petroleum mixture as general anesthetics and the methods of spinal anesthesia and the local anesthesia (Schleich) have been brought forward by enthusiastic advocates, but each in turn either set aside or its field of usefulness greatly limited. Of these later methods the local anesthesia of Schleich with proper limitations bids fair to become a permanent aid. Its sphere however, seems to be chiefly for minor or moderately severe operations, the former class including the removal of small tumors in the skin, and

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

the latter removal of goiters, etc. Its application must necessarily be somewhat limited, and neither it nor the use of spinal anesthesia can ever hope to supplant the use of general anesthetics.

I have tabulated below that which clinical observation and experimental study in animals has taught us in regard to our two most frequently used anesthetics, ether and chloroform. It will not be necessary to re-

lates the heart, chloroform directly depresses it. The heart muscle is very sensitive to the poisonous effect of chloroform and death may be caused by its toxic action on the heart ganglia alone.

Embley has lately shown that chloroform raises the excitability of the vagus mechanism and stimulates the central medullary vasomotor system, causing great fall in blood pressure, and this directly produces

Their physiological action can be compared as follows:

	ETHER.	CHLOROFORM.
Arterial Tension and Blood Pressure.	Greatly increases both.	Gradually decreases both.
Heart.	Stimulates, and in zone between these large doses paralyzes. Quite large.	Depresses and in larger doses paralyzes. Zone between these two small.
Lungs.	Has slightly direct irritating effect, causing some increased Tracheo-Bronchial Secretion. Stimulates respiratory center and large doses paralyze. Zone very large.	Slows respiration and in larger doses paralyzes. Zone not large.
Mouth, Nose and Pharynx.	Greatly increases all secretions. Large doses paralyze muscles of Tongue, Epiglottis and Palate. Both above favor aspiration.	Scarcely any effect on secretions. Large doses also paralyze Tongue, etc.
Stomach and Intestines.	Considerable nausea and vomiting. Moderate tympanites.	Less nausea than ether as a rule; in large doses causes some fatty degeneration of muscles.
Liver.	No effect.	Prolonged administration causes fatty degeneration, with decreased glycogen, icterus, and in fatty liver may cause acute yellow atrophy.
Kidneys.	In normal kidneys transitory effect (casts and traces of albumin), decreased amount of blood and secretion. In diseased kidneys has a bad effect; may cause Anuria and Uremia.	In ordinary administration and normal kidneys but slight transitory effect. In prolonged administration causes considerable fatty degeneration.
Temperature.	Lowers it.	Lowers it less than ether.
Pupils and Corneal Reflex.	Pupils contracted some and respond. Corneal reflex of some value.	Pupils somewhat contracted but respond. Secondary dilatation of pupil bad sign. Corneal reflex of little value.

peat in detail the names and results of the investigators including work of my own which has permitted this tabulation. There is no question that chloroform according to every statistic is far more dangerous than ether. In 240,806 chloroform anesthetics collected by the German Surgical Society, there were 116 deaths or one in 2075 cases. In 56,333 ether anesthesia there were 11 deaths, one in 5,112.\* Whereas ether stimu-

a failure of respiration. Upon the lungs chloroform probably has no direct local effect as it has upon the heart. It produces a slowing of respiration and a failure through the fall in blood pressure. Ether on the other hand stimulates the respiratory center and has a slight local irritating effect seems to be the case, due perhaps to the tracheal and bronchial mucous glands. On the mouth, nose and pharynx chloroform



has directly no effect, whereas ether greatly stimulates their secretions especially that of the salivary glands. Ether as a rule produces more nausea and vomiting than chloroform, although at times the opposite seems to be the case, due perhaps to the toxic action of chloroform upon the kidneys, and the resultant uremic condition. Ether has no effect on the liver, whereas chloroform when administered for a long time causes fatty degeneration and icterus. In cases of fatty liver it may cause acute yellow atrophy, as has been observed several times. Upon the healthy kidney chloroform has about the same effect as ether; that is transitory (2-3 days), appearance of casts, and traces of albumin. This is somewhat more frequent as I observed it in 110 cases with chloroform than with ether. Prolonged administration of chloroform, however, has a bad effect upon the parenchyma of the kidney in the same manner as it has upon that of the heart muscle, it produces fatty degeneration, and may cause death a number of days after the anesthetic has been given. Upon the diseased kidney some still contend that ether has no effect but my own clinical observation of cases of uremia following ether administration and the reports of Emmett and Weir would seem to be sufficient grounds upon which to base the opinion, that it has a bad effect and may cause anuria and uremia. Both chloroform and ether at first dilate the pupil which is rapidly followed by a contraction during which latter period they respond to light. In case of chloroform this response to light is one of the best guides as to the depth of the narcosis and as soon as the pupil begins to dilate for the second time, that is after it has been contracted syncope is already present.

When should we give chloroform and when ether? (1) Ether should not be given when there is increased arterial tension and blood pressure, for example in atheromatous conditions. (2) It should not be given when there is great tympanites or under conditions which will interfere with the actions of the diaphragm. (3) It should not be given to nephritic patients for the reasons above stated. (4) It should not be given when the post-operative treatment requires a pro-

longed recumbent position, for as I will state later the hypostatic congestion of the lungs plus the increased amount of salivary secretion which latter ether causes favor the development of pneumonia. (5) Ether is contra-indicated in individuals who have from any cause a hyperemic condition of the respiratory tract. The increased secretions which it causes are so frequently aspirated into the lungs. Contra-indications to the use of chloroform are: (1) Any condition in which there is decreased blood pressure owing either to great loss of blood or some systemic disease for under these conditions the tendency of chloroform to increase the already diminished blood pressure will cause a rapidly fatal syncope. (2) It is contra-indicated in affections of the heart in which there is lack of compensation, in myocarditis and in pericardial adhesions. The opinion which is pretty generally held at the present time is that there is no contra-indications to its use in ordinary valvular or functional forms of heart conditions. I have had occasion to administer chloroform to a number of patients with compensated valvular affections and could not observe any unpleasant symptoms. The cardiac disease which perhaps requires the greatest care according to some is aortic disease. At a recent meeting of the Paris Medical Society the general conclusion was that there was no objection to administering chloroform to patients with heart disease provided there was compensation and no myocarditis. (3) Chloroform should not be administered in the so-called status thymicus or the thyroid state. Kundrat in 1895 first called attention to the regularity with which the administration of chloroform was followed by death in this condition. He reported at that time 12 fatal cases, and recently Laquer reported the similar case in a child, and Strassmann found this condition 4 times in 10 autopsies for chloroform administration. It is frequently impossible to diagnose this state before operation, but we should bear it in mind. It consists in enlargement of the faucial and lingual tonsils, persistent and enlarged thymus gland and enlarged spleen. (4) Chloroform should not be given in either acute or chronic septic conditions, the heart being

already greatly weakened through the action of the toxins. (5) Chloroform should never be given when it is necessary to administer it for more than an hour on account of its degenerative effect upon the heart muscle and parenchyma of the liver and kidney. There are certain general diseases which we should hesitate greatly to administer either chloroform or ether, for example, diabetes, leucemia, and cachectic conditions, etc. A number of cases have been reported of diabetic coma following administration of an anesthetic.

*Administration of Anesthetics.* Kionka has shown that in order to produce narcosis with chloroform it is only necessary to have from one-half per cent to one and three-tenths per cent of chloroform in the inspired air. In order to accomplish this an ordinary Es-march mask, covered with gauze two layers thick, must be used, and not a towel and handkerchief. It should be given drop by drop. In order to overcome a paralysis of the muscles of the tongue and ligaments of the epiglottis and the resulting closure of the glottis, the patient should be kept on the side as much as possible during the administration of the anesthetic, especially chloroform, and the anesthetizer should be taught the best method of pulling the jaw forward.

In the use of ether one must remember that this anesthetic greatly stimulates the secretions of the mouth, nose and pharynx. Their aspiration has been beautifully demonstrated by Lindemann and Holscher. There is with every inspiratory effort a direct aspiration of this mucus into the finest bronchi. These investigators stained the mouth secretions and found them in the finest bronchi after one hour's anesthesia. This aspiration of the mouth secretions with their myriads of organisms has frequently caused pneumonia following operations. In case of ether we can avoid this aspiration to a certain extent by giving ether in a diluted form on an Es-march mask, as first shown by Dr. Prince, and avoiding as much as possible the older method of asphyxiation.

Kionka has also shown that it is not necessary to have 97 parts ether and 3 parts air, as many have formerly thought, but that it suffices to have a mixture of from 2 to 8

per cent ether with the inspired air. With every anesthetic a larger quantity is necessary to produce sleep than to continue it. We can also aid in avoiding pneumonia after ether by adhering to the same rules as in chloroform, keeping the head dependent below the level of the trunk and turned on one side. There is little danger in using ether, other than the bronchial irritation if these suggestions are strictly adhered to.

It was formerly thought that acute pulmonary complications following operations were more frequently found with ether than with any other anesthetic. Mickulicz has shown that the percentage is relatively larger in local anesthetics (Schleich) than if a general anesthetic is given. In the last few years 1007 goitre operations and laparotomies with general anesthesia (chloroform) were followed in 7.5 per cent of the cases by pneumonia, and of this 3.4 per cent died. Of 273 similar operations under local anesthesia 12.8 per cent were followed by pneumonia, of which 4.10 per cent died. This shows that we can no longer blame the general anesthetic as being the chief cause of pulmonary complications following operations.

It is now generally believed that these complications may be due to one or a combination of the following factors: First, they may follow an anesthetic, especially ether, when given in too concentrated a form, due to the fact that the mouth secretions are aspirated into the trachea and bronchi and may give rise to a bronchitis, lobular, and lobar pneumonia. Second, they may be hypostatic and this may occur with ether as well as with chloroform, due to the recumbent position, diminished heart's action, close fitting dressings and to the tympany following operations, which is frequently a result of the paralysis of the muscular fibers of the intestines. Thirdly, there may be aspiration of the particles of food, and this may occur with ether as well as with chloroform, giving rise to pulmonary abscesses and gangrene. Fourth, embolism, and this is the frequent explanation of the causes, including those in which cocaine has been used, of the pulmonary complications of which we have spoken. This is especially frequent after operations in the pelvis and strangulated her-



nias, and where there has been any previous anemia or in cachetic individuals.

We can avoid these complications to some extent by remembering that both ether and chloroform lower the temperature of the body. Chilling, which is due to unnecessary exposure of patients and the overheating of the operating rooms and the application of moist aseptic towels, should be avoided as much as possible. The operating table whose glass top can be heated by hot water bags would seem to be the ideal condition. In older persons stimulants should be given as a preparation before and after anesthesia. The patient should never be kept in a recumbent position too long a time. They should be encouraged to take deep breaths after the operation. Tympany may be somewhat relieved by the use of turpentine enemata. Whenever it is permissible we should try to operate under local anesthetics (Schleich) as much as possible. As a preparation for any operation to avoid accidents the urine should be carefully examined in a twenty-four hour specimen for casts, albumin, sugar and percentage of urea. It has been observed that latent diabetes is brought into prominence and may cause death by diabetic coma after anesthesia.

Examination of the urine after anesthesia will frequently show the cause of persistent headaches and nausea to be uremia. Patients should be encouraged, if possible, to take fluids freely after operations, and if this is not possible, be given enemata of salt solution at regular intervals. In case a large quantity of blood has been lost and the blood pressure lowered, an intravenous salt transfusion may be given during or after operation, as many a life has been saved in this manner. A quarter to one-third grain morphia given before the anesthesia begins will greatly diminish the difficulty of anesthetizing alcoholics. Amongst other preparations, the empty condition of the stomach intestines and removal of foreign bodies from the mouth, a bath given not too soon before the operation and absolute mental quiet are requisite.

Having taken all these precautions to prevent an accident, how can we best treat them. First, in case of a syncope following either

the administration of chloroform or ether, especially the former, after which it is more frequent, there should be in the minds of every operator a certain sequence or routine of methods of resuscitation. In every hospital or ambulatory clinic the anesthetizer should be taught that in order to be successful in treating a syncope there must be no confusion. Every method must be tried in a certain more or less fixed succession. This will, of course, vary somewhat with the experience of the individual operator.

The main points are to begin early and systematically. Artificial respiration begun one-half to one minute after syncope has begun has been shown to be of no avail. The moment, or rather second, that the cessation of either pulse or respiration is noticed, raise the foot of the table. Do not lose valuable time trying to get hypodermics with heart or respiratory stimulants ready. They are of no benefit when there is no circulation to carry them to the heart. The plan of many operators is to begin first of all with artificial respiration by the well known method of raising the arms as far as possible above the head and then bringing them down upon the thorax in a flexed position, at the same time making firm pressure against the side of the chest with the elbow of the flexed arm.

I have been in the habit of using the method of König-Maas, massage of the heart, as the first method after raising the foot of the table. This consists in making pressure over the precordial region at the rate of about 120 times to the minute. It is practically a shaking up of the heart and acts by mechanically stimulating the heart muscle and thus preventing clotting of the blood in the ventricles. I have never failed to obtain an immediate response, so that the heart would begin to contract again very promptly. During the past three years I have had occasion to try the efficacy of this method in seven cases of syncope, all in the deep state of narcosis. The anesthetic was given in hospital or dispensary work by undergraduates in four and by graduates in the other three. There was unquestioned cessation of the heart, as was remarked at the time, before that of respiration, in six cases. This primary cardiac paralysis is far more fre-



quent than is generally believed. Mikuliez found 34 primary cardiac and 6 primary respiratory syncope in 44 cases. In four there was simultaneous cessation. Such a primary heart syncope is a very serious condition and must be promptly met. In all seven cases shortly after the massage of the heart was begun, the heart was felt to contract again and then with the aid of a second method, which I believe ought to be tried either at the same time or immediately after, the respirations soon returned.

This second method is that of Laborde, rythmical tractions of the tongue. This is done by taking hold of the tip of the tongue with volsellum forceps, pulling it out as far as possible at the rate of 16 to 18 times a minute. It acts by stimulating the respiratory center reflexly through the glossopharyngeal and superior laryngeal nerves. I believe that ordinarily one of these three methods, artificial respiration, massage of the heart and tongue traction will suffice. But in case of the continuance of the syncope there are a number of other excellent methods which have saved some apparently hopeless cases. They are the methods of Prus, intravenous transfusion, and the intratracheal insufflation of air.

The method of Prus was first proposed in 1900 as the result of experiments on dogs. Out of 21 with cardiac paralysis following chloroform 16 were resuscitated by this method. During 1901 a case of a human being kept alive for 8 hours after all other methods had failed was reported by Maag. The heart did not begin to beat until it was grasped by the hand, placed inside of the thorax and then it continued to beat for 8 hours, although the respirations did not begin spontaneously until half an hour after the heart had begun to beat. This method of Prus certainly ought to be tried in desperate cases. It consists in opening the pericardial cavity and making the same movements while the heart is held in the hand as one would in compressing a rubber ball. Before reading of this, I resuscitated a dog by a similar method with the hand introduced into the left pleural cavity two years ago. The object is the same as that of Konig-Maas, viz.: to stimulate the heart me-

chanically. The only difference is that in the Prus method the heart is caused to beat by the direct contact of the hand, while in the other it is done through the chest wall.

Intravenous transfusion accomplishes remarkable results when combined with one of the other methods. Korte rescued a case which had seemed hopeless 40 minutes after the heart had ceased to beat. He employed the method of Konig and transfusion. This is to be especially recommended when the syncope is due partly to the sudden lowering of blood pressure due to chloroform and a considerable loss of blood.

Another method for use in desperate cases is to perform a tracheotomy and introduce a Trendelenburg balloon canula and then insufflate with the aid of pair of pillows. The object of the special canula is to prevent the entrance of the air into the stomach and intestines, thus pushing up the diaphragm. The stimulus to the lungs has been found to start up respiration after syncope.

Amongst other methods I might mention are the electrical stimulation of the phrenics, stretching of the sphincter ani, irritating the fauces, the finger inserted into the throat and acupuncture of the heart. (McArthur.)

In regard to the ether accidents, their prevention is the more important. The pneumonias and other pulmonary conditions should be treated as they would if they arose from other causes. To sum up:

(1) Chloroform has a narrower zone of safety than ether. Its toxic effects are as a rule manifest at the time of administration. Ether is the cause of death in many cases through renal or pulmonary complications from hours to days after the anesthesia. The late deaths due to chloroform are so rare as to render this factor practically of no importance. Chloroform is a more dangerous anesthetic than ether and must be watched far more carefully.

(2) Chloroform kills more frequently through primary cardiac than respiratory syncope, and the anesthetizer must constantly watch the decrease in volume and rapidity of the pulse indicating the fall of blood pressure and the slowing of and more shallow respiration. Chloroform syncope can be avoided by keeping the head low, if possible

turned to one side, keeping the jaw forward, watching the pulse respiration and pupil, keeping the patient's mind quiet, and keeping the anesthetic well diluted with air.

(3) Ether rarely causes death through its immediate, but more frequently through its after effects such as pneumonias and uremia. These complications may be avoided by keeping the head lower than the level of the body, turned to one side and not giving it in too concentrated a form, also by not keeping patient on the back too long and relieving post-operative tympanites as soon as possible. The contra-indications to the use of chloroform are myocarditis, pericardial adhesions and non-compensated valvular disease. In all other forms of heart disease it may be given. It should not be given when the blood pressure is low or in status thymicus or when a prolonged anesthesia is necessary.

(4) The pulmonary complications are relatively more frequent with local anesthesia than if a general anesthetic is given. They may be due to aspiration of mucus or food, or due to hypostasis and to embolism. The latter is far more frequent than is commonly thought. Avoid these by exposing patients as little as possible. Use heated operating tables, avoiding recumbent position and tympany.

(5) Avoid renal complications by careful examination of the urine before anesthesia.

(6) Begin process of resuscitation immediately and systematically in the following order: Elevate foot of table, artificial respiration, the method of Konig-Maas or massage of the heart, rythmical traction of the tongue, method of Prus or direct exposure of the heart and intravenous salt transfusion. The writer prefers to begin with massage of the heart and the Laborde method (rythmical tractions of tongue.

#### Discussion.

W. A. Kuflewski, of Chicago: Mr. President—In the first place, I want to congratulate Dr. Eisendrath on his excellent paper. I desire to say a few words in reference to the accidents of anesthesia. A very important point is to select a competent man to anesthetize the patient, and this should not be overlooked by the surgeon. A good, if not the best, man is selected to perform the operation. We should

select a man to administer the anesthetic who has the confidence of the patient.

Another thing: The anesthetizer should not do anything except to attend to the administration of the anesthetic. The anesthetic should be administered a few drops at a time. It is easy to determine whether ether is pure or not. You simply take the ether, put it in a trough, and mix it. If you have a clear mixture, the ether is pure; if it is a milky mixture, it is impure. If you take a dram of chloroform and put it on a blotter, it evaporates and leaves no odor. That chloroform is pure. But if it leaves an odor, it is impure.

The patient should not be allowed to assume the horizontal position. In giving ether or chloroform, I administer it by the closed method, and not by the open method, as advised. If you have gaslight or candlelight, always hold the anesthetic above the blaze, because the vapor of ether is heavier than air. If you do not do this, you may have an explosion. I never use stimulants in connection with anesthesia. I do not believe we should use morphine or strychnia or nitroglycerine before using an anesthetic. Sometimes I start with chloroform, and not with ether, but I never give what is known as the A C E mixture. Perhaps it would be advisable to use nitroglycerine, if it is really necessary, after anesthesia, but I never use it before.

Thomas J. Sullivan, of Chicago: The question of accidents in operations on anesthesia of vital importance. In giving chloroform we should always have in mind the risk of sudden death. This should not be lost sight of, and if it is kept in mind, we will often avoid some of the dangers. Most of the patients who die from the administration of chloroform die usually in the dentist's chair, where it is given for the extraction of teeth, or for some dental operation, or where the anesthetizer is watching the steps of the operation.

Without being able to make a comparison of anesthetics, I will say that I have been giving chloroform as an anesthetic for twenty years, but recently, on account of many close calls, I have given it up almost entirely, and now resort to the administration of ether by the open method, that is, giving it by the drop method. We all know ether is one of the safest anesthetics were it not for its after-effects. If we can eliminate the after-effects, we have an ideal anesthetic. Those who have given it a long trial, namely, the Mayo brothers of Rochester, Minnesota, claim that we can eliminate nearly all, if not all, the dangers from ether anesthesia by giving it by the open or drop method. By giving ether drop by drop you obviate the accumulation of bronchial secretion when the patient is on the operating table. When you give ether slowly, your patient does not have renal complications afterwards. That has been proven abundantly in something over four hundred operations where this method was carried out by the Mayo brothers of Rochester. I have been carrying out that method of open anesthesia for some time, and have been much pleased with it. The general practitioner, who is often called upon for the extraction of teeth, if he will give chloroform to a patient upon the operating table, and have the teeth extracted



In the Rose position, he will avoid many of the dangers of chloroform narcosis in the extraction of those teeth. In giving ether by the open method, drop by drop, four ounces will usually answer the purpose. In alcoholics there is usually more or less disturbance, and this can be avoided by preceding anesthesia with one-eighth or one-quarter of a grain of morphine hypodermically.

**A. H. Andrews**, of Chicago: It is very important, as Dr. Eisendrath has pointed out, that the anesthetist shall know what to do in a case of accident. It should be clearly defined in his mind. It should also be well understood by him how to do the things which he intends to do to resuscitate the patient.

A few weeks ago I was talking in an amphitheatre to students when my patient was being anesthetized in another room. A nurse motioned me to come out. I did so, and did not really know what my anesthetizer was trying to do. I thought, perhaps, he was trying to use the method which Dr. Eisendrath has mentioned and demonstrated of stirring up the heart. He was certainly doing something vigorously. We went to work and tried to produce artificial respiration for a few minutes. I cannot tell you the number of excuses and explanations I had to make to the patient to account for the great discomfort which she experienced from the stirring up which the doctor gave her chest.

One more point in the use of whatever anesthetic we employ. I believe that the anesthetic should be commenced slowly. I have the testimony of a number of patients where the anesthetic had been pushed rapidly from the beginning, and the feelings which they experienced were very disagreeable, and as humane beings we should manifest some regard for the feelings of our patients, who say that the feeling is indescribable of being choked with ether.

**Lucy Waite**, of Chicago: In connection with the paper of Dr. Eisendrath, I wish to relate a case, as I think we sometimes learn a great deal from the differential indications in the use of chloroform and ether. The patient was a young woman upon whom I operated for a simple case of appendicitis. There was nothing unusual connected with the operation except that the appendix was adherent to the fundus of the uterus. She took the anesthetic very well apparently; the operation consumed about thirty minutes. The urine was not examined before she was brought to the hospital. She was given chloroform as an anesthetic. After the operation she was put back to bed, and during the first twenty-four hours the kidneys only secreted a few ounces of urine, and from that time she went on from bad to worse, and in spite of our efforts to stimulate the action of the kidneys, and everything we could think of was done, she died forty-eight hours later from uremic convulsions.

**J. F. Percy**, of Galesburg: I want to mention one method which Dr. Eisendrath did not refer to, but which I have used in one case, and that is traction on the tongue. This has helped us materially in cases of trouble we have had from anesthesia. It is true, the more experience one has with the administration of anesthetics, the less trouble. In the Mayo clinic,

which has been referred to, I understand that they have used this method in six thousand cases, and if you want to see an anesthetic given in an ideal way by this method, you want to see it done there. They never have any trouble. They do not have to run around and do the things we have heard spoken of today. When we have to do the things that have been spoken of, there is something wrong with the anesthetizer, in the majority of cases. We may not have a good anesthetizer. The anesthetizer in the Mayo clinic at Rochester has given all of these anesthetics, practically six thousand, and while on a visit in Germany I was told that one man there in one of the large clinics had been giving anesthetics in that clinic for twenty years. They did not have trouble even in desperate cases. It is usually a reflection on the operator when these accidents happen. Traction on the tongue is of material assistance in some of these cases where we have trouble during anesthesia. One time I had the case of a prominent old man suffering from hemorrhoids. It was merely a hemorrhoidal operation by the clamp and cautery method. My anesthetizer informed me that the patient had stopped breathing, and said he could not get the respiration started. This occurred after first giving chloroform and following it by ether.

I have long ago given up the idea of using a hypodermic syringe, because I consider it a waste of time to attempt to inject a heart stimulant under the skin with a hypodermic syringe. If you use nitroglycerine, you will get just as quick and prompt effects by dropping it on the tongue. This is the only drug, with the addition of nitrite of amyl, that is worth considering under these conditions.

Here is a method or suggestion that I got from somewhere. In one case I took a stomach tube and ran it down the patient's stomach, poured in water at a temperature of 115° F., and the picture I got within a short time was beautiful. If there was ever a resurrection on the operating table, it was right there. From a ghastly look, with widely dilated pupils, the patient changed into a beautiful red glow all over the body. Ever since I have thought a good deal of the stomach tube in such cases, and I shall continue to use it.

I wish to commend the doctor's paper because it deals with an important subject. It is equally important to the operation itself, and the way anesthesia is produced by the majority of men in the practice of medicine is appalling. In one neighboring town, near me, not long ago there was a physician who gave an anesthetic and kept the patient under its influence for three hours in order to permit a dentist to extract one tooth. It is time that men should know that they have no right to give anesthetics unless they understand the fundamental principles, certainly some of the dangers, of their use.

**Charles B. Reed**, of Chicago: Admitting the general truth of Dr. Eisendrath's statement, that ether is safer than chloroform, I wish to refer to the immunity observed in the use of chloroform in obstetrical cases, which, aside from its desirability by reason of convenience and facility, possesses a decided advantage in these cases.



As Dr. Eisendrath states, the danger arises from the effect upon the circulation, but in obstetrical cases the physiological hypertrophy of the left ventricle not alone preserves the normal condition of the circulation under the great strain of labor, but in this work it is ably assisted by the intermittent contractions of the uterus, which now assumes the place of a huge abdominal heart and protects the circulation.

**Dr. Eisendrath** (closing the discussion): I believe the ideal condition is to have regular anesthetizers, men or students trained to give anesthetics skillfully, and in our colleges we should train as many as possible to give anesthetics. They should be taught the fundamental principles, and the risks or dangers attending the administration of anesthetics. It is the only practical method to adopt in hospitals where internes necessarily must change every six months.

As to the purity of the drug, I think it can be left out of consideration, because the average ether and chloroform which we get are pure.

As regards the use of the Esmarch mask in alcoholic patients, it does not always work satisfactorily. Instead of that, I usually give patients chloroform carefully, and then continue with ether, or give them one-quarter of a grain of morphine before anesthesia.

As regards the use of stimulants, I do not wish to be misunderstood. I never give them except in cases of laparotomy, and there I make it a routine procedure to give the thirtieth of a grain of strychnia twenty-four hours before anesthesia, on account of its action on the intestines.

As regards the use of chloroform and ether, I wish to say that I limit the use of chloroform to operations on the mouth, nose, throat, and in cases of laparotomy.

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### PROF. LORENZ'S BLOODLESS REDUCTION OF CONGENITAL DISLOCATION OF THE HIP JOINT.\*

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BY EDMUND ANDREWS, M.D., LL.D.,

Professor Emeritus of Surgery in the Northwestern University, Chicago.

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Much interest has been excited by the fact that a citizen of Chicago has called Prof. Adolph Lorenz, of Vienna, to come across the sea and reduce, by his bloodless method, a congenital dislocation of the hip joint in a child five years of age. The Professor came and operated successfully. During his stay he was invited to give clinics in Mercy Hospital and other institutions, where he applied his method to a considerable number of similar cases. As I observed

his procedure closely, a condensed statement of the whole subject may be of interest.

Congenital dislocations of the hip joints are somewhat rare. When they occur it is the opinion of obstetrical authorities that the displacement of this joint takes place some time before birth, and almost never as an accident of the delivery. It appears to be due to imperfect development of the acetabulum, the head of the femur, and of the capsular ligament. In other words, the undeveloped mechanism of the joint allows the head of the femur to be gradually drawn or pressed upward and backward *in utero*, and before labor commences.

During the last ten years efforts have been made to treat these cases by two methods:

1. By incisions down to the joint.—Through the open wound the operator clears out the acetabulum and when necessary enlarges and deepens it by curetting and gouging the bone. He then places the head of the femur in the enlarged cavity and closes the wound aseptically.

Dr. Hoffa reported 248 open wound operations with ten deaths. About half the operations were perfectly successful. Of the other half ten died, as above stated, and the remainder had more or less imperfection of the function of the joint.

2. The bloodless operation.—Prof. Lorenz, of Vienna, gave his attention earnestly to the development of this method. Five years ago he published a large number of cases, and since that many more. He seems to be a candid man. He admits failures, and lays no claim to infallibility. He says that from 50 to 70 per cent of the children obtain a perfect functional cure, so as to be able to run, jump, and use their limbs as well as anyone, but that anatomically the X-ray and other methods of examinations detect in these successful cases some harmless deviation from perfect form or structure. The remaining cases, amounting to about 40 per cent, are usually greatly benefited, but still not functionally perfect.

Mickulicz, of Breslau, in Germany, has also published a large number of cases of

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\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

the bloodless operation, and claims a very high success.

Lorenz's ideas and methods are as follows: The child should be allowed to reach an age above two years and not over five or six years before operating. In older children the operation becomes more difficult, and although some successes are obtained among them the ratio of failures is large. Prof. Lorenz brought with him from Vienna a highly trained assistant and several pieces of special apparatus to enable him to apply proper force to the limb and to hold the patient in desired positions.

Anaesthetics were given in full quantity. He remarked that it was of great importance to avoid haste in applying the necessarily great force, and insisted that one must proceed "*slowly—slowly*," so as to stretch and rupture the opposing muscles and ligaments very gradually, otherwise bones would be fractured. He says he has fractured the neck of the femur quite a number of times, but the shaft only once. His manipulations consist of flexions, rotations, tractions, and finally very great forced abductions, so as to put the three adductor muscles on a violent stretch and make them rise up a firm, hard ridge under the skin near their origin at the pubis. Then, while an assistant maintains this powerful tension by forced abduction, he manipulates this muscular ridge pretty near the pubis by a chopping motion of the border of the hand and the pressure of the thumbs and of the closed fist until by great force and determined persistence he tears off the three great adductors from their origins at the pubis and ramus of the ischium. At the same time all the other tissues which resist extreme abduction are slowly stretched or torn until the femur is thoroughly loosened and the thigh can be swung freely out so as to stand out laterally at right angles to the axis of the body. This part of the operation gives an impression of terrific violence to one who sees it for the first time, and the necessity of judgment and skill in the operator is most manifest. The manipulations, rotations, and tractions are now patiently and adroitly continued until the head of the bone is felt and heard

to snap into the acetabulum, or upon its rim, if the cavity is not large enough or empty enough to fully receive the head. If it is a double dislocation, both sides are treated in the same way, the bones are placed in position, with the two thighs standing out laterally at right angles to the body, for in no other position is it possible to keep the head of the femur down upon the acetabulum, because those cavities are in many cases very imperfectly developed.

The next step is to wrap the thighs, as well as the pelvis, thickly with cotton compactly bandaged on. Some strips of soft porous cloth are laid next to the skin under the cotton, and extending above and below it, for purposes presently to be mentioned. Next plaster of Paris bandages are applied over the whole length of both thighs and across the back and front of the pelvis, so that the pelvis and both of the thighs are encased in one inflexible mass. The knees and legs are left free. The strips of soft cloth laid next to the skin and running beneath the plaster dressing are used to cleanse the skin from time to time by pulling them to and fro, and are renewed as often as needful by sewing clean strips to the ends of the soiled ones and then pulling them into position. The anus and urinary outlets are left uncovered.

The plaster splint is kept on about six months, and sometimes longer, but the patient is allowed, after the first few days, to get out of bed and hobble about. When the splint is taken off the thighs are found, of course, to be standing out somewhat stiffly at right angles to the body. They must not be suddenly brought down, but by very slow and gradual manipulation from day to day, they are brought back to the line of the body. By this time the heads of the femur will be so well settled into the acetabula, either by adhesion or by repair of the capsular ligaments and synovial membranes, that they will remain there securely in most instances. In a few cases they will fail to preserve perfectly their correct position, but even then they are much nearer to it than before the operation, and much more useful for walking.

It is perhaps too early as yet to determine with absolute certainty the relative value of the two methods, but my belief is that Lorenz's bloodless operation will be found the safest, and will, on the average, give the most useful limbs.

American surgeons are favorably impressed with the personal qualities of Prof. Lorenz, both on account of his great skill in manipulation, and of his apparent honesty in admitting his failures when they occur.

Operations somewhat similar to his have occasionally been done by Chicago surgeons, but it was a great pleasure to see the method demonstrated by the one most distinguished as its author and developer.

## PROCEEDINGS OF STATE SOCIETY.

Minutes of the Fifty-Second Annual Meeting Held at Quincy May 20-22, 1902.

The next thing in order was the report of the Treasurer, which was read by Dr. Everett J. Brown, of Decatur, as follows:

### REPORT OF THE TREASURER.

May 19, 1902.

Everett J. Brown, Treasurer, in account with the Illinois State Medical Society.  
Dr.

To Cash on hand May 18, 1901.....	\$883 14
" Dues paid at Peoria.....	749 00
" Exhibitors at Peoria.....	371 80
" Virchow subscription .....	83 60
" Journal advertisements.....	265 61
" Interest .....	16 73
" Receipts as per Book 1 ....	\$323 00
2 ....	320 00
3 ....	220 90
4 ....	300 00
5 ....	300 00
6 ....	291 00
7 ....	306 00
8a....	78 00

Total .....\$2,138 00 \$4,508 78  
Cr.

By Voucher 1—Bills paid and approved after preliminary report at Peoria.....	\$291 18
By Voucher 2—Illinois State Journal Co .....	1,563 81
By Voucher 3—Expense acct Judicial Council .....	125 15
By Voucher 4—William Whitford .....	144 70
By Voucher 5—William Osman & Son, printers.....	20 20
By Voucher 6—Marquam & Co., printers .....	4 25

By Voucher 7—Ophthalmic Record .....	7 69
By Voucher 8—E. R. Le Count .....	40 74
By Voucher 9—Coe Bros., stationery .....	1 45
By Voucher 10—G. N. Kreider, 4,500 letters .....	111 00
By Voucher 11—Passenger Ass'n Agent .....	23 00
By Voucher 12—Williams & Baird, printers .....	15 95
By Voucher 13—E. W. Weis, expense and honorarium.....	376 14
By Voucher 14—William Osman & Son .....	68 26
By Voucher 15—L. E. Wheeler, P. M., Springfield.....	21 21
By Voucher 16—Everett J. Brown, expense .....	52 00
By Voucher 17—Everett J. Brown, honorarium .....	150 00
By Voucher 18—G. N. Kreider, expense .....	150 00
By Voucher 19—G. N. Kreider, Editor .....	600 00
By Voucher 20—Legislative Committee .....	493 35
	4,259 08
By balance in bank.....	249 70
	\$4,508 78

THE PRESIDENT: What disposition will you make of the report of the Treasurer?

DR. JAMES H. STOWELL: I move that it be received and adopted. Seconded and carried.

THE PRESIDENT: We will now listen to the report of the Committee on Medical Societies, Dr. C. W. Hall, Chairman.

### REPORT OF THE COMMITTEE ON MEDICAL SOCIETIES.

DR. HALL: Mr. President.—My report will be very brief. There have been 16 new County Societies organized the past year, namely, in Alexander, Edwards, Franklin, Grundy, Jersey, Johnson, Knox, Kendall, Livingston, Marshall, Pope, Randolph, Pulaski, Rock Island, Stark and Union. The Decatur City Medical Society embraces Macon County, and the Peoria City Medical Society embraces Peoria County.

We have now 69 county organizations in this State. There are 102 counties, leaving only 33 counties to be organized. I have promises from gentlemen present that this number will be cut down three or four before we adjourn. There are 11 district organizations, and 23 city organizations, giving a total, with the 69 county organizations, of



103 medical organizations in the State of Illinois. If we keep up the present rate, and we intend to do so, in two or three years at least every county in the State of Illinois will have a medical organization.

On motion of Dr. Brower, the report was adopted.

Dr. Carl E. Black, of Jacksonville, read the report of the Committee on Medical Legislation, as follows:

#### REPORT OF COMMITTEE ON MEDICAL LEGISLATION.

Mr. President and Members of the Illinois State Medical Society.—Your Committee, appointed to consider subjects for medical legislation, would respectfully submit the following report:

We reported so fully last year that it will not be necessary to offer a voluminous report at this time. There is little or no difference in the theory and practice on which the Committee has acted since our last meeting. At that time we were instructed by your Honorable Body to draft a bill to be presented to the next session of the Illinois Legislature for the establishment of a Board of Medical Examiners in the State of Illinois. Heretofore, the work regulating the practice of medicine has devolved upon the State Board of Health. Your Committee has endeavored to make a study of all the Medical Practice Acts now in force in the various States of the Union. Out of these we have sought to select the best points for Illinois. Considerable correspondence has been had with the secretaries of almost every State board in the Union, and many valuable suggestions have been received from them.

There are several points which we have constantly kept in mind: First, we have sought not to change the present law, excepting where it was absolutely necessary, in order to adapt it to a special Board or to correct existing errors. We have sought to follow as nearly as possible the decisions of the Supreme Court of Illinois regarding the practice of medicine, believing that every point in our law which has stood the test of the Supreme Court is worth preserving.

We began our work with the determination of framing a law so broad that it would provide amply for any and every sect which now

exists or might ever exist in medicine, and at the same time would be so comprehensive as to make it unnecessary to mention or recognize in law that sects in medicine existed. How well your Committee has succeeded in this you must judge. It has been the one desire of the Committee to carry out the wishes of the profession. To this end we have addressed every member of the various societies in the state, asking for suggestions regarding this law. We have notified every member of every local medical society in this State to attend the preliminary meeting of this society for the discussion of this law.

The Committee only wishes to carry out the desires of the profession. No member of the Committee has any pet scheme or hobby which he wishes in the bill. The Committee feels that a bill which is framed upon the consensus of opinion of the medical profession will certainly be enacted into law by our Legislature, because it will have the support of the profession.

Incidental to framing this bill for establishing a Board of Medical Examiners and a new Medical Practice Act, it is necessary to frame a new law for the guidance of the State Board of Health. This work is in the hands of one of this Committee, the Secretary of the State Board of Health, who is more competent than any one else in the State to frame such a bill.

Of course, none of the bills framed or endorsed by your Committee will be in shape to present to the Legislature until they have had the careful scrutiny of some thoroughly trained legal mind.

Your Committee feels that considerable has been accomplished during the past year to carry out the suggestions made in our report a year ago. There is still much lack in uniformity and organization which interferes with satisfactory work. However, largely due to the energies of our Honorable President, a considerable number of new counties have been organized, and now have healthful and helpful societies.

The Article of Incorporation proposed this year by your Committee on reorganization, will be of great aid in securing more uniformity.

In conclusion, your Committee would say that we have been not only willing, but anxious, at all times, to receive the suggestions and criticisms of every member of this society. We have been anxious to serve you and carry out your wishes. The labor involved in carrying on the work of the Committee can be agreeable only when accompanied by the realization that we are being of service to our profession and to our fellow members of this great State organization. We wish to thank you all for your hearty co-operation. During the coming year the Legislative Committee will be especially in need of your individual support. The Committee would like, before closing this report, to impress upon every member the fact that while the individual is an important unit in securing proper medical legislation, no one man—no single group of men—can influence a Legislature continuously and always for good; but your Committee firmly believes that whatever is demanded of the Legislature by the four thousand practitioners in our affiliated societies will be granted almost without question. If your society, and you, as individual members, will give this Committee your support, we believe that right and proper legislation will be promptly and easily secured.

Again thanking you for your support to this Committee, and soliciting a continuance of it for future Committees, this is respectfully submitted.

(Signed) Carl E. Black, Chairman.  
E. Fletcher Ingals,  
J. A. Egan,  
J. T. McAnally, Ex-Officio,  
Legislative Committee of the Illinois State  
Medical Society.

On motion of Dr. James H. Stowell, the report was adopted.

The next thing in order was the report of the Committee on Necrology and Biography, which was read by Dr. O. B. Will, as follows:

#### REPORT OF COMMITTEE ON NECROLOGY AND BIOGRAPHY.

Mr. President: My esteemed colleague and chairman of your Committee on Necrology, Dr. J. H. Hollister, finds it again impossible to be with us at our annual meet-

ing, and has requested me to act in his stead in making the necessary report.

I therefore herewith present the names of those members of this society who have passed away during the year, in so far as they have come to our notice. I regret to say that the list is a strikingly lengthy one, and includes the names of a number who have for years been especially prominent in our work and councils.

Dr. W. S. Caldwell, for many years a most active, energetic and enthusiastic worker in the Society, passed to the great beyond from his home in Freeport on June 7, 1901.

The next to leave us was Dr. Caleb DuHadway, of Jerseyville, who was for fifteen years a member and contributor to the interests of the Society.

Dr. Katherine Miller, of Lincoln, long an active participant in our labors, and one of the most prominent representative physicians of her sex, died on August 1st, 1901.

Dr. N. S. Read, of Chandlerville, likewise a member of many years' standing, died in Virginia on August 11th, 1901.

Dr. S. J. Jones, the prominent oculist and aurist of Chicago, and for many years Secretary of this Society, departed this life October 4th, 1901.

Dr. Cephas Park, of Oquawka, for nearly twenty consecutive years a member, died September 23, 1901.

Dr. Frederick C. Winslow (formerly of Jacksonville), Superintendent of the Insane Asylum at Peoria, died suddenly in Chicago on October 10th of last year.

Dr. Christian Fenger, the celebrated surgeon, who honored the Society by his frequent demonstrations, died at his home in Chicago on March 7th of the present year.

Dr. Albert C. Corr, an ex-president of this Society, and whose genial presence enlivened each meeting for many a year, likewise passed beyond the pale of this life only the 3d of last month, April, 1902.

And just on the eve of coming to the present meeting, we have been apprised of the death at his home in Bloomington, after a protracted illness, of Dr. John L. White, also an ex-president of this Society and a former member of the Illinois Legislature.

Thus is ended, in so far as we know, the sad record for the closing year. Commentaries of just appreciation of the lives and work of some of these deceased members, together with appropriate biographical sketches, are herewith appended; some are in course of preparation, and others will be made as quickly as the material can be secured, for reference to the committee on publication, so that they may be presented to the members as soon as practicable through the medium of the Journal.

In this connection I wish to suggest the desirability of the Society taking some action respecting the matter of securing the portraits of deceased members for publication in connection with their biographical notices. One of the most impressive features of the older bound volumes of the transactions was the presence of the euts. For those turning the pages they serve as sort of gallery of immortals, recalling old faces and pleasant memories, and I beg to express the hope that the pages of the Society's Journal may continue to be illumined by these quick reminders of the existence and work of heroes gone.

My associate on the committee, Dr. J. M. G. Carter, I think, agrees with me as to the wisdom of this recommendation, and also further that it would be more in consonance with the fitness of things, as suggested by your editor, Dr. Kreider, if your future committees on necrology were instructed to furnish him the obituary notices and biographical sketches of deceased members in consecutive order as soon as practicable after deaths occur, and without waiting for the annual report. Such a course would avoid the embarrassment of congested columns for two or three issues of the Journal immediately following the annual meeting, and no doubt prove much more satisfactory to readers and friends.

All of which is respectfully submitted.

For the Committee,

O. B. Will.

John H. Hollister,

O. B. Will,

J. M. G. Carter,

Committee.

It was moved and seconded that the report be adopted. Carried.

The Auditing Committee, composed of Drs. M. L. Harris and J. W. Hensley, reported that it had examined the accounts of the Treasurer, and had found them to be correct.

On motion, the report was accepted.

DR. FRANK P. NORBURY: I move that the Nominating Committee be instructed to elect the Chairman and Secretaries of the three sections for the coming year, in accordance with the authority given them yesterday. Seconded and carried.

THE PRESIDENT: I will announce the names of the special committee appointed to consider the recommendation of the Judicial Council—Drs. Joseph Robins, J. W. Pettit, Harold N. Moyer, Daniel R. Brower and W. F. Grimstead.

Dr. C. W. Hall read the report of the special committee in regard to the Rock Island County Medical Society, as follows:

REPORT OF THE COMMITTEE ON THE COUNTY ORGANIZATIONS OF ROCK ISLAND COUNTY, ILLINOIS.

To the Illinois State Medical Society:—There are two rival county organizations in this county, known respectively as the Rock Island County Medical Society and the Rock Island County Medical Association.

The Rock Island County Medical Society organized November 12, 1901, as follows:

A selected number of regular physicians convened on the above date, and other regular physicians, some of them members of the State Medical Society, were purposely excluded from that convention. The call to the meeting did not indicate a purpose to organize a County Society, but the organization was, nevertheless, effected. Of those elected to membership, some were not present and had not applied for membership. Six have resigned.

The Rock Island County Medical Association organized November 20, 1901, as follows:

A mass meeting of the whole regular profession of the County was called for the purpose of organizing a county medical association. Every regular physician of the county was invited. The six gentlemen who resigned from the Society have joined the Association.



Your Committee finds that the Rock Island County Medical Society is not properly organized, in that a mass meeting of the profession was not called to effect an organization, and in that certain members of the State Medical Society were purposely excluded from the organization proceedings. Therefore, the Rock Island County Medical Society cannot be regarded as a representative body. The exclusive character of the basis of this organization appears to have compelled the formation of another organization on a broader basis in consonance with the spirit of generosity which pervades the profession.

Your Committee also finds that the Rock Island County Medical Association was properly organized on such a basis, and is, therefore, a representative body.

Nevertheless, in view of the excellence of the membership of both organizations and the disposition to unification manifested by both parties, your Committee recommends that the Rock Island County Medical Association be recognized as the county organization of Rock Island County as soon as it has received into full membership every member of the other organization who wishes it.

C. W. Hall,

J. W. Pettit,

Wm. E. Quine.

DR. HAROLD N. MOYER: I move the adoption of this report. Seconded.

DR. J. R. HOLLOWBUSH: I move that the report be laid on the table. Seconded.

The President put the motion of Dr. Hollowbush, which was lost.

The motion of Dr. Moyer was put and carried.

THE PRESIDENT: We will now listen to a report on National Conference by Dr. Carl E. Black.

Dr. Black read the following report:

#### NATIONAL CONFERENCE.

Mr. President and Members of the Illinois State Medical Society:—At our last meeting in Peoria you appointed me to represent you at the National Conference with the Committee on Medical Legislation of the American Medical Association. It was my pleasure and privilege to attend the meeting and participate in its deliberations. As

you doubtless remember, this conference consisted of one representative from each State Medical Society, one representative each from the army, navy, and marine hospital service, with the Committee on National Legislation of the American Medical Association, of which Dr. H. L. E. Johnson, of Washington, is Chairman. The meeting was held at the Arlington Hotel, in Washington, on April 10th and 11th. There were twenty-four representatives present.

The subjects considered more or less fully were the following:

Reports of Committees of the Second Annual Conference:

1. Committee on "Uniform Legislation on Basis of Uniform Medical Education."—Drs. Emil Amberg, Dudley S. Reynolds, John B. Roberts.

2. Committee on "State Medical Organization."—Drs. C. R. Shinault, D. P. Goff, L. B. Tuckerman, H. M. Bracken, Charles E. Quimby.

3. Committee on special Congressional Bills, Last Session: S. 4171, Quarantine Bill; H. R. 13423, Codification Postal Laws.—Dr. L. B. Tuckerman.

4. Committee on Reorganization Bill.—Dr. G. M. Sternberg.

5. National Committee ad interim. Annual Report. Committee on National Legislation.—Drs. H. L. E. Johnson, Wm. H. Welch, W. L. Rodman.

New Business:

6. Official action of conference of State Health Officers at Washington, D. C., March 12-13, 1902, and their recommendations to Congress, and the third annual conference, in connection with pending National Health bills, viz: Perkins Bill, S. 2162, to increase the efficiency and change the name of the United States Marine Hospital; Hepburn Bill, H. R. 7189, duplicate of Perkins Bill; Spooner Bill, S. 2417, relating to quarantine and public health; Ray Bill, H. R. 10595, to establish a board of public health and for other purposes.

7. Bills and Acts: Gallinger Bill, S. 189, for the further prevention of cruelty to animals in District of Columbia; Nelson Bill, S. 569, (now an act of Senate with report 82), to establish the department of

commerce and labor; Hay Bill, H. R. 1952, to define the duties of the medical department of the Army of the U. S.; Kern, H. R. 1650, to re-establish the army canteen; Proctor Bill, S. 2172, to provide for the payment of the medical expenses of sick officers and enlisted men of the army while absent from duty with leave or furlough.

8. Communication from Dr. John J. Riley, U. S. Army, Manila, Philippine Islands, with proposed amendment to Sec. 18 of Act 4300, approved February 2, 1901, bearing the endorsement of the Legislative Committee of the medical officers of the U. S. Army at Manila.

9. Reports of delegates (State Societies).

10. Miscellaneous.

A brief synopsis of the actions of the conference has already been published in the *Journal of the American Medical Association*, April 19, 1902, page 1023. It is hardly necessary for me to repeat what has been printed there. The decisions of the sessions were principally upon the report of Dr. Emil Amberg, Chairman of the Committee on Uniform Legislation, on the basis of uniform education, in which the committee sought to recommend a bill for the establishment of a national board of health and medical examiners, in preference to reciprocity.

Two points were made against the Committee's report: 1st, that the Constitution of the United States would not permit the formation of a national board of examiners, as this would interfere with the rights of the States. The second point was that reciprocity was impracticable, because a bill cannot be so framed as not to appear to grant privileges to a certain number of licentiates in our State which it denied to others. It is perfectly proper for the law to accept certain licentiates of other States who have passed an examination of high grade. This is not reciprocity. Whenever the law reads that such privileges may be granted, provided similar privileges are granted to a certain class of licentiates in our State, we divide our licentiates into two classes, and discriminate against one class in favor of the other. This view being generally accepted by the conference, resulted in a proposition by Dr. Rodman, of Philadelphia, advocating

the organization of "a voluntary national board of medical examiners." The plan suggested is to constitute a board of six or more members, composed of the surgeons general of the army, navy and marine hospital service, and three equally prominent civil practitioners, two to be elected by the House of Delegates of the A. M. A., and one by the American Congress of Physicians and Surgeons, and possibly a seventh member to represent the national board of examiners. Dr. Rodman says, in an article published by him on this subject, in the *Journal of the American Medical Association*, May 10, 1902, page 1215: "This board would at once have the confidence of the profession, as it would be comprised of able men, absolutely above suspicion. The time of the meeting should be from June 1st to July 1st, so as to accommodate the graduates of all schools. The examinations should be both theoretical and practical. Applicants should be taken into the wards of the hospitals and be given opportunities to make diagnosis and examination of urine, sputum, and blood, as well as the outlined course of treatment."

Following this suggestion, which was accepted by the conference, I have introduced into the proposed Medical Practice Act suggested to be presented to the next Legislature in Illinois, a clause providing that the Board of Examiners may, in its discrimination, accept the certificate of some such high grade national examining board.

There is great interest in the official action of the Conference of state Health Officers at Washington, March 12-13, last, and their recommendations to Congress and this conference, on the several pending national health bills were considered and approved. They recommend the adoption of the Perkins-Hepburn Bill, with the following amendment to Section 7: "That when, in the opinion of the Surgeon-General of the United States Health Service, the interests of the public health would be promoted by a conference with the state or territorial boards of health or health authorities, the District of Columbia included, the Surgeon-General of the United States Health Service may, or, on the application of the five state boards of health or quarantine officers, he

shall invite representatives of state boards of health, and the quarantine officers to send delegates—not more than one from each state and territory and District of Columbia—to said conference.”

This plan, if adopted—and it is meeting with considerable favor—will practically give us a national board of health of high grade. This, combined with a voluntary national board of examiners, would mark a considerable progress in securing more uniform health and medical laws.

The conference devoted some time to a discussion of Senate Bill 189, Gallinger Bill, for the further prevention of cruelty to animals in the District of Columbia, and recommended adverse action by Congress. Dr. Welch presented a resolution against the adoption of the bill, and was appointed a committee of one against this sense of Congress to the House and Senate.

Surgeon-General Geo. M. Sternberg, of the army, was listened to with great interest regarding medical conditions in the army. It is a well-known fact that the position of the Surgeon-General as a military man has never been properly recognized in this country, nor is the position of medical man of the army generally recognized as it should be. Much might be said about the work and character of General Sternberg, but you are all more or less familiar with it.

A glance at the functions of the Medical Department of the army will convince any unprejudiced person of the enormous responsibilities attaching to its chief. They are:

First. To investigate the sanitary condition of the army and make recommendation in reference thereto.

Second. To care for the sick and wounded.

Third. To make physical examinations of officers and enlisted men.

Fourth. To manage and control military hospitals.

Fifth. To recruit, instruct and control the hospital corps and nurses' corps.

Sixth. To furnish all medical and hospital supplies for the department.

It will be observed from the foregoing that the responsibilities of the Surgeon-General attach primarily to men (sec-

ondarily, to material). He has control of, and is responsible for, the sick of the entire army and the personnel necessary to their care.

Assuming that the sick number 7 per cent, and the personnel 5 per cent, it is seen that 12 per cent of our army constitutes the command of the Surgeon-General. With us today that means a responsibility for twelve thousand men, which is about the equivalent of a division. But aside from these twelve thousand men, the functions of the Surgeon-General extend widely beyond that of a Major-General of the line, for he has advisory supervision of the sanitary condition of the entire army. He must direct the examination of every recruit who enters the service, and of every man who is discharged for disability; of every officer at entrance, promotion, etc. He must recruit, instruct and discipline the hospital corps, a body of nearly five thousand men. He must organize supervise and direct the administration of all military hospitals, and he must purchase the medical and surgical material necessary for the service. No other officer in the army combines the dual function of control of personnel and the supply of material as is done by the Surgeon-General, and no other officer has the responsibilities that attach to him.

General Sternberg's military services have been so important, so devoted, that his appointment as Major-General would be but just recognition thereof. This certainly should be done as a mark of appreciation by his country of his services as a soldier.

In consideration of the distinguished services of the Surgeon-General, the following bill has been submitted to Congress with the endorsement of the A. M. A.: Be it enacted by the Senate and House of Representatives of the United States of America, in Congress assembled, that the President of the United States is hereby authorized to select one from the medical officers of the army, who has served forty-one years or more, nine years of which as Surgeon-General, and by and with the advice and consent of the Senate, appoint him a Major-General of the United States Army for the purpose of placing him on the retired list.



There are other equally important matters in the army which need attention, and on which it seems very difficult to get a fair and proper hearing. There was considerable discussion on these subjects, brought about by a consideration of the army reorganization bill, as proposed by Dr. Jno. J. Reilly, of the United States army to the legislative committee of medical officers of the United States army, U. S. A., at Manila, Philippine Islands. It appears from Dr. Reilly's bill and the discussion on this subject participated in by General Sternberg and others familiar with the subject, that while there is at present no bill before Congress relating to an increase of the medical corps of the army, there is a great necessity for such increase. It is considered, however, that the best way to obtain legislation for the benefit of the medical department of the army will be to first convince the Honorable Secretary of War of the necessity for such legislation. A bill introduced with his approval and support subsequently by the American Medical Association, would be very likely to become a law; but it would be very difficult to obtain the enactment of a bill which did not meet with his approval. He is deeply interested in the welfare of the army and the improvement of all branches of the service. The bill drawn by a committee of medical officers in the Philippine Islands and transmitted to the Committee on Legislation of the American Medical Association, meets with the approval of the Surgeon-General of the army, with the exception of that clause which proposes to reduce the number of assistant surgeons. Such an increase in the higher grades as is provided for in this bill would be an incentive for the best qualified young medical men in the country to present themselves for examination, and would give us an increase of 32 in the number of medical officers allowed by law. There are at present 65 vacancies which would be created by the promotion of medical officers now in service if the bill referred to should become a law, would give us in all 97 vacancies. It is probable that it would take at least two years to fill these vacancies, and, in my opinion, no additional legislation for the regular medical corps should be asked for until these

vacancies have been filled. It is true that we would still be largely dependent upon volunteer medical officers and contract surgeons for the care of our troops in the United States and in the Philippine Islands. But a clause in the army bill now before Congress, which has the approval of the Honorable the Secretary of War, provides that the time of the 200 volunteer medical officers shall be extended for one year from March next; that is, to March, 1904. In the meantime it is probable that the conditions in the Philippine Islands will be such that the army there may be considerably reduced and a smaller number of medical officers will be required. Without doubt, however, a further increase in the medical corps of the army will be imperative when the 200 volunteer medical officers are fully mustered out of service, and Congress should at that time be called upon to enact the necessary legislation.

Your representative was one of a committee of two to wait upon the Honorable the Secretary of War in the interest of the reorganization of the medical department of the army. While Secretary Root and General Corbin, who was present at the interview, seemed to entirely disagree with the proposition made, they gave the committee a very liberal and respectful hearing. The principal point made by the committee was that positions in the medical department of the army were not desirable. They are not attractive to medical men. Young men of talent, such as the army examination requires, are not willing to accept these positions under existing circumstances, and as a consequence there now exist over 65 vacancies which the department cannot fill, notwithstanding the fact that at least once the standard of requirements has been reduced. At the same time the government is employing over 200 contract surgeons. It seemed to the committee that the Honorable, the Secretary of War was unable to give any satisfactory explanation of this state of affairs. The committee was impressed with the idea that the Secretary is open to further suggestions along this line.

Altogether, the conference resulted in considerable valuable discussion. Each State

representative reported on conditions in his State, and no doubt all received some valuable hints to be put into operation before returning home.

Carl E. Black,  
Special Committee to the National Conference on Medical Legislation.

On motion of Dr. Brower, the report was adopted and referred to the Committee on Publication.

At this juncture, Dr. George Dock, of Ann Arbor, Mich., was introduced, who delivered the address of Section One. He selected for his subject, "Pernicious Anemias; Their Diagnosis and Treatment."

At the conclusion of the address, Dr. Daniel R. Brower moved that a vote of thanks be extended to Dr. Dock for his interesting, valuable and scientific paper. Carried.

Adjourned.

#### SECTION TWO—SECOND SESSION.

Dr. J. F. Percy, of Galesburg, read a paper entitled, "Malignant Disease of the Kidney in Children."

Discussed by Drs. Ochsner and Eisendrath.

Dr. Louis E. Schmidt, of Chicago, read a paper entitled, "The Technique and Possibilities of Endovesical Operative Procedures," which was discussed by Dr. Frank, and in closing by the essayist.

Dr. J. B. Murphy, of Chicago, followed with a paper on "Prostatectomy," which was discussed by Dr. Lydston, and in closing by the essayist.

The Chairman stated that the Section would now take up the matter of nominating a Chairman for the Section, also a Secretary, the names to be handed to the Nominating Committee.

Dr. John B. Murphy nominated Dr. Wm. E. Schroeder for Chairman of Section Two for the ensuing year; and Dr. J. W. Hensley nominated Dr. E. M. Sutton, of Peoria, for Secretary. Both nominations were accepted.

As members of the House of Delegates, Dr. E. Mammen, of Bloomington, and Dr. Edward H. Oschner, of Chicago, were nominated, one for the term of two years, the other for one year. Their alternates are Dr. Joseph B. De Lee, of Chicago, for the two

year term, and Dr. Brown, of Sycamore, for the one year term.

Adjourned.

#### SECOND DAY—AFTERNOON SESSION.

##### SECTION TWO—THIRD SESSION.

Dr. D. N. Eisendrath, of Chicago, read a paper on "Accidents of Anesthesia, Their Prevention and Treatment."

Discussed by Drs. Kuflewski, Sullivan, Andrews, Waite, Percy, Reed, and the discussion closed by the essayist.

Dr. C. B. Reed, of Chicago, read a paper on "Transverse Arrest of the Head an Indication for Forceps."

Dr. Joseph B. De Lee, of Chicago, followed with a paper on the "Use of the Colpeurynter in Obstetric Practice."

Dr. Effa V. Davis, of Chicago, read a paper on "Care of the Perineum During Labor and the Puerperium, Based on a Study of Five Hundred and Fourteen Cases."

Dr. C. S. Bacon, of Chicago, contributed a paper entitled "Some Points in the Prevention and Management of Post-Partum Hemorrhages."

These papers were discussed jointly by Drs. Brown (Sycamore), Will, Brown (Decatur), Waite, Bacon, and the discussion closed by the essayists.

Dr. W. C. Bowers, of Decatur, read a paper entitled "The General Practitioner and His Surgery."

Dr. E. E. Clark, of Danville, read a paper on "Dacryocystitis."

Dr. I. L. Firebaugh, of Robinson, read a paper on "Ophthalmia Neonatorum."

Dr. W. O. Nance, of Chicago, read a paper entitled "Nephritic Eye Lesions."

Dr. J. Whitefield Smith, of Bloomington, read a paper entitled "Voluntary Nystagmus (?)."

These four papers on eye affections were discussed jointly by Drs. Andrews, De Lee and Sisson.

Dr. W. A. Kuflewski, of Chicago, read a paper on "Ambulatory Treatment of Fracture of the Femur."

Adjourned.

# The Illinois Medical Journal.

The Official Organ of the State Medical Society.

EDITOR—George N. Kreider, A. M., M. D., Springfield.

Official Reporters of Affiliated Societies—

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Bureau County—H. E. Owens, M. D., Princeton.  
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## DISTRICT SOCIETIES.

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Brainerd District—J. L. Lowrie, M. D., Lincoln.  
Central Illinois—F. J. Eberspacher, M. D., Pana.  
Galva District—C. W. Hall, M. D., Kewanee.  
Fox River Valley (Kane and McHenry Counties)—F. H. Jenks, M. D., Aurora.  
Military Tract—C. B. Horrell, M. D., Galesburg.  
North Central—Geo. A. Dicus, M. D., Streator.  
Southern Illinois—E. E. Fyke, M. D., Olney.  
Tri-County—Leroy Jones, M. D., Hoopeston.  
Western Illinois—H. A. Chapin, M. D., Whitehall.

## URBAN SOCIETIES, EX CHICAGO.

Alton Medical Society—Geo. E. Wilkinson, M. D.  
AuxPlaines Medical—W. R. Livingston, M. D., Maywood.  
Decatur Medical—Lynn M. Barnes, M. D.  
East St. Louis—C. W. Lillie, M. D.  
Jacksonville Physician's Club—D. W. Reid, M. D.  
Peoria Medical—C. U. Collins, M. D.

All communications should be addressed to the Editor, 522 Capitol Ave., Springfield, Illinois.

The Society does not assume responsibility for any statements or opinions published in the JOURNAL.

The JOURNAL is published monthly. The subscription price is \$3.00 per annum in advance. The JOURNAL is furnished free to the members of the Society.

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McLean County—E. S. Reedy, M. D., Bloomington.  
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Winnebago County—S. R. Catlin, M. D., Rockford.

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Southwestern—Thos. J. McGonagle, M. D.

DECEMBER 1902.

## IMPORTANT NOTICE—DATE OF MEETING CHANGED.

In another column will be found the Secretary's report of the meeting of the Executive Committee. We desire to call particular attention to the change in the date of meeting, which, for reasons fully explained, will be held the last days of next April and the first days of May. Probably our Society has never held a meeting as early as this,

but we can see many advantages. First, the meeting will antedate the New Orleans meeting of the A. M. A. Second, the weather will probably not be as oppressively warm as it was at Quincy, and has often been during our meetings. Third, it will be held on four separate days, each of which will be filled with events of interest to every physician in the State. We hope that every one of our 4,000 members can get to Chicago



during at least one day. Partners can each arrange to attend part of the time. An effort is being made to arrange for one fare to cover the cost of transportation. Much smaller and less important organizations than ours have secured such concessions from the railroads, and there is no good reason why we should not. We firmly believe that there will be such an attendance that all records of medical meetings in America will be broken.

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#### THE CHICAGO MEDICAL SOCIETY.

Cook County, heretofore the greatest wilderness in Illinois, is being awakened. For many years the hundreds of streets in Chicago have been the hiding places for thousands of physicians who seemingly owed no allegiance to society or profession. Each came and went for himself, envious, jealous, exultant, according as his neighboring colleague succeeded or failed in his life work. In many of the rural counties 90 per cent of the profession were united in social organizations, while in Cook County 75 per cent were connected with no organization. As a result of this unfortunate condition of affairs the professional body as a whole has suffered. It is perhaps not remarkable, under these circumstances, that the moral standard of the profession was low. It could scarcely be otherwise.

But a change is being brought about. New ideas are being urged in the County (Chicago) Society. Every practitioner with a semblance of respectability is being urged to affiliate. Society members are learning that every disciple of Aesculapius, from the freshman medical student to the oldest and most learned practitioner, must be taken into the reckoning. Each has his influence for weal or woe. To this end the territory has been divided into twelve districts, each with its Chairman. These Chairmen appoint ten

or more assistants, and in this manner are doing such effective work that an average of twenty names are reported as applicants for membership each week. The meetings of the Society are so well attended that the hall heretofore used is becoming too small, and larger and better quarters must soon be secured. The influence of this activity will not be confined to the Chicago; it will be felt in the State and nation.

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#### THE CORONER OF PEORIA COUNTY.

The profession of Peoria County have had good cause for complaint, because of the ignorance or maliciousness of the County Coroner in attacking several of the most reputable medical men in the City of Peoria. It seems that a boy, Willie Curtis, aged eight years, an inmate of the Home for the Friendless, was injured by a companion striking him in the abdomen with a piece of brick. After two days he was removed to the hospital, where explorations were made seeking to determine the cause of his dangerous symptoms. After his death the surgeons desired to make a post-mortem, which was denied them by the coroner, who proceeded to scandalize the whole profession by charging that the lad's death was the result of experimental operations.

Fortunately, there is a large and harmonious medical society in the city, which, as one man, proceeded to smite this minion of the law, and so thoroughly that probably nothing further will be heard of the base slander.

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#### TYPHOID BACILLI IN THE BLOOD.

It was formerly believed that a true bacteremia in man during the course of the ordinary infectious diseases occurred but seldom. A variety of organisms, it is true, have been found in the blood, but only in a small proportion of cases. These bacteria include the colon and typhoid bacilli, the

bacillus of tuberculosis, the pneumococcus and the common pyogenic cocci. Except for the added information relating to the processes of disease, the demonstration of their presence in the blood has proven of little value. The termination of the cases in which they were found, indicated that their presence in the blood warranted an unfavorable prognosis.

The older conceptions of sepsis and sapraemia as conditions brought about solely by the absorption of the soluble products of bacteria have never possessed other than theoretical value, and there are good reasons for believing that refinements of bacteriologic technic will in the course of time destroy the limitations between these speculating conditions and true pyaemia or septicaemia, or possibly abolish some of them entirely.

In making cultures from the blood, quantities of blood were employed at first that were too small to include many bacteria, and in adding the blood to culture media an insufficient amount of the latter was often employed. In this way mistaken ideas of the bactericidal power of the blood or blood serum gained prevalence. The modifications which the methods employed in such investigations have undergone, have in many instances given new and different results, and corresponding changes in our views have been necessary.

Recent examinations of the blood for bacteria indicate that it is not commonly invaded, yet such a process is by no means as rare as formerly supposed; the failure to find bacteria is not so frequently attributed to the bactericidal action of the blood.

It is not unlikely that further elaboration of the methods employed will demonstrate their presence, perhaps in small numbers, in many of the more common infections, in which, up to the present time, they have been

demonstrated only in exceptional cases or shortly preceding death.

The recent announcement by Schottmuller\* that the typhoid bacillus occurs in the blood in most all cases of typhoid is very important for two reasons: the symptoms of typhoid have been heretofore attributed to an intoxication; by the proof of the presence of the bacilli in the blood in the majority of cases, typhoid becomes as well, a septicaemia or true bacteremia.

This announcement is also important, since by finding the bacilli in the blood at very early periods in the disease, a measure of great diagnostic value has been attained, since the agglutination test is not of use until later in the course of the disease.

Schottmuller examined the blood in a large number of cases of typhoid, and carried on this investigation for several years; he found the bacilli present in 84 per cent of the cases, and in numerous cases as early as the fourth day of the disease. In cases of recurrence he was successful in demonstrating its presence in the blood a number of times during the first twenty-four hours of the attack.

He withdrew the blood by a syringe from a vein in the arm, having previously exposed the vein by a small incision and a bandage above the point selected.

Plates were made by adding the blood, 2 or 3 cm. to each plate, to melted agar at 45 degrees C., in the proportion of 1 of blood to 2 or 3 of medium. The colonies did not all appear until after two to four days of growth, or later, but as a rule the growth was sufficient to enable a diagnosis in twenty hours. The number of bacteria per cubic cm. of blood appeared to bear a relationship to the height of the fever and severity of the symptoms; as many as 1,800 were found per cu. cm., and this was in a

\*Munch. Med. Wchn., 1902, XLIX., 1561.

case that recovered; as a rule the bacilli numbered 110 to 300 per cu. cm.

Although for the present such methods of diagnosis require well equipped laboratories as well as some experience, it is none the less consoling to realize that such positive data may be obtained and assist in the recognition of doubtful cases. Meantime, it should be perfectly practicable to employ the method of diagnosis of typhoid in all hospitals, both large and small, by bacteriologic examination of the blood.

#### OTHER STATE SOCIETIES—MICHIGAN.

Illinois and Michigan are bound together not only by a community of interests as neighbors, but by other ties which are partly historical and more particularly domestic and now existing. In the past a great many distinguished medical men have come out of the peninsula to become leading teachers in our great metropolis. Among these we recall the names of Adams, Andrews and Gunn. In the present a very large number of our people and not a few physicians make an annual hegira to the beautiful lakeside resorts of Michigan. As a knowledge of the climate extends the number of these summer residents increases. We of Illinois are therefore interested in all that pertains to the improvement of the profession in Michigan. Our readers will be pleased to learn that the Michigan State Society is one of the first to adopt the modern Constitution, is organizing rapidly by counties, and has established a monthly journal to take the place of the antiquated volume of Transactions. The Journal, is similar in size and appearance to this Journal, and is ably edited and managed by Drs. A. P. Biddle and S. E. Sanderson, both of Detroit. The subscription price is two dollars per annum, and our readers could profitably become readers of

this Journal also. In the September and October numbers President Leartus Connor tells the history of the Michigan State Medical Society, which is one of unusual interest. While Michigan was still a territory and General Lewis Cass its Governor, one John L. Whiting, who had been licensed as a physician by the Medical Society of his native State, New York, located in Detroit. He was but twenty-six years of age, and there were only a dozen physicians and eight thousand people in the territory when he organized the Society in 1819. What a lesson for the profession in some of our counties of much greater population is the enthusiasm of this young pioneer, 'who grappled with the most important problem which a physician owes to his profession and the public. For thirteen years the enthusiasm of this one man did much to keep the Society alive. Unfortunately, in 1832 he abandoned the practice, because he lost three patients in succession; but the Society continued its existence, unbroken, until 1851. During these years it represented the people in guarding the doors of the profession. It examined candidates and granted certificates, which in effect were degrees of M. D. During this first period of its existence the Society licensed 250 persons, one of the candidates licensed to begin the study of medicine being our venerable and valued member, Edmund Andrews, of Chicago, who was granted this privilege by the Wayne County Society, March 6, 1850.

It now seems strange that a Society thus early and firmly established should have failed to continue its existence, especially as the State was rapidly growing in wealth, population and the means of communication. President Connor says:

"Among the obvious causes of its downfall were:

"First. The commercial disasters of 1857.



"Second. The growlings of the approaching civil war.

"Third. The natural operation of the feuds of former years.

"Fourth. The lack of stimulus from opposition.

"Fifth. Last, but not least, the absence of the sustaining interest of many local Societies."

He also intimates that rivalry between the Medical Department of the State University and other aspiring medical centers have played a part in destroying the old Society and hampering the growth of the new. It is hoped and believed that the folly of this sort of business has become apparent, and that for the future each member will strive to see who best can work, who best agree. The State Society re-organized in 1867 after a hibernation of 12 years, although small, has done much to promote the development of State Insane Asylums in lieu of the wretched county lazzar houses for the herding of the insane. It initiated the movements that led to the formation of proper registration of deaths, births and marriages; some sort of restriction of free trade in medical practice to those competent for the work; and numerous other enterprises having for their object the application of the latest scientific knowledge to the betterment of the physical lives of our citizens. The Society since June has increased its county organizations from fifteen to nineteen, with twenty more in the process of organization.

Under the new Constitution, and with the aid of the Journal, we may reasonably hope to see the Society take a leading place in the fraternity, and, paraphrasing the motto of Michigan, say: *Si Quaeris Medicorum Societatem Amoenam, Circumspice.*

#### NEW FEATURES OF THE JOURNAL.

Unusual activity in Medical Society affairs exists this fall. Four counties have started

organizations in the past thirty days, and still others are moving. The county without a Medical Society is now the exception, not the rule. As a result of all this activity there has resulted a congestion of the columns of the Journal and radical treatment has become necessary. No less than 104 pages are required to print the matter offered this month and there is no likelihood that we can ever return to a fewer number of pages. It is no longer expedient to bind the Journal as heretofore, and a cover is necessary. On its first page we have stated the actual membership of the State Society, and this will be kept carefully revised each month. There is apparently now a net growth of about 150 per month. Hereafter the advertising pages will not be reckoned in the paging, as has been done in the past. We hope our members and readers will continue to read the advertisements carefully, as we are under great obligations to our patrons, and all of them are worthy. In this issue 24 local Societies make reports. The success of this section of the Journal has been far beyond the expectations of the most enthusiastic members. The papers read before the local Societies are in nearly every case of great worth and often of extreme value. We have had it in mind for some time to start a consultation column, where the members could relate their difficult cases and solicit answers relating to diagnosis and treatment. Several journals have built up a great circulation by catering in this manner to a class of practitioners who are a little lame (and who is not lame at times), in their knowledge of diagnostic and therapeutic methods. The journals catering to these inquirers have been misleading them by catering to their prejudices and advising proprietary remedies of their own make for their cases. It appears that there is no reason, except a sentiment why this Journal

should not take up this idea and develop it in a legitimate way. We therefore will ask our members and readers to send in their questions, and shall endeavor to have them answered fairly and legitimately. It has been our policy to confine ourselves solely to the consideration of the medical news of Illinois. The crowded condition of our columns proves that there is here an ample field for such a Journal. The probability is that there is now enough to fill a weekly publication, and that before many months a weekly issue will be necessary.

#### THE LEGISLATIVE COMMITTEE.

This committee is actively engaged in preparing the text of the new law and in securing the votes of legislators necessary to pass it. Without an exception, Societies have endorsed the propositions of the committee and have pledged money to assist in the work. The chairman informs us that while a number of individuals and Societies have sent in money, a great deal more is necessary, and he is now sending out a second appeal. Experience in the past leads to the belief that our members will respond liberally and ample funds will be provided.

#### CORRESPONDENCE SCHOOLS OF NURSING

In the list of new incorporations will be found a correspondence school of nursing, and we understand several of these teaching (?) bodies are in existence already. It appears that several men connected with medical schools went into this sort of work, and were promptly informed by the officers of the schools that they could not do it and remain on the faculty of the schools. The result was that the correspondence school work was dropped. It is probable that men will be secured who can not be thus easily reached. To squelch such travesties on teaching it becomes necessary to have some central body to control. Why would it not be

a good idea to place them under the supervision of the new Board of Medical Examiners? It will probably be impossible to get the legislature to establish a Board of Examiners of Graduate Nurses. We believe the nurses will not insist on having such a Board if they can be assured that their interests will be looked after by our board.

#### EDGAR P. COOK.

Our beloved ex-President Cook has left us. Full of years and honors, he has gone to his reward. For twenty-five years he has been a power in the State Society. We shall miss his valuable councils, his knowledge of professional men, his ability to smooth off the rough places. An appreciative obituary by ex-President Will appears in this issue.

#### PROFESSOR LORENZ.

Altogether the most remarkable medical event of the fall has been the advent of this distinguished foreigner, who has been at once the personification of surgical learning and skill and of modesty and good breeding. We are pleased to give place in this issue to an excellent description of his operations, written by so good an authority as Prof. Edmund Andrews. The reception given to the distinguished foreigner has been very creditable to the profession of Chicago. On the other hand we understand that the Professor has a lively appreciation of the courtesies extended him and will return to the Kaiserliche Konigliche Hauptstadt, Wien, with many pleasant memories of the new world.

#### THE ROCK ISLAND COUNTY MEDICAL SOCIETY.

Harmony prevails throughout the State—all is quiet on the Mississippi. The two Societies in Rock Island have been amalgamated. We congratulate President Harris and all concerned, upon this happy conclusion of internecine strife. The details will be found in our Society Columns.

### Death of Dr. E. P. Cook.

Dr. E. P. Cook is gone. He passed away at his home in Mendota, Illinois, on the evening of the 31st, ult., from a repeated attack of angina pectoris. This announcement can but bring sorrow to the heart of every member of the Illinois State Medical Society. To not again see Dr. Cook at their meetings will recall the experience of going home to find the old chair vacant. Following closely upon that of Drs. Corr and White, the death of Dr. Cook suggests the all too rapid disappearance from our ranks of those older members who have served as presiding officers of our Society and been a bulwark of strength in sustaining its organization through all the years of its existence down to the present time.

Of all his associates none has been more active, more energetic and more efficient than has Dr. Cook. He has for nearly a generation been an almost constant attendant at the meetings of the State Society, and been one of its guiding spirits through all the vicissitudes of its being. He was so well acquainted with all the personalities and influences at work in the organization that he was able, when others failed, to harmonize the conflicting interests in keeping with sacred traditions and the spirit of true progress.

Genial, yet dignified in method and manner, he was not only most helpful in all that made for the best, but an inspiration to his comrades, both young and old. He was a counsellor of the greatest value, and none will miss him more than his associates on the Judicial Council, over whose latest meeting in Chicago he presided with all his old-time vigor only a few weeks ago.

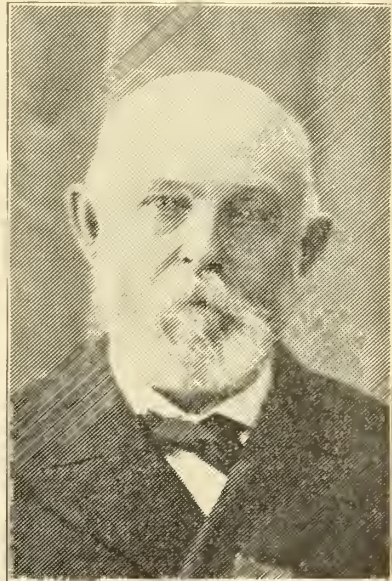
Edgar Pumphrey Cook, eldest son of Dr. Wm. J. Cook and Drusilla Pumphrey Cook, was born in Wellsburg, West Virginia, May 2, 1833, and died in Mendota, Illinois, October 31, 1902. In 1836 his parents removed to Ohio, residing in Middletown, Guernsey County, for a time, then in Freeport, Jefferson County, and finally in East Springfield, Jefferson County. His mother, who was herself the daughter of a slave holder in old Virginia, early acquired an abhorrence of slavery, and the family's removal to Ohio was largely due to her desire that her children should grow to manhood in a free State. His father was a graduate in medicine of the University of Maryland in the class of 1826, and his earliest associations were with the profession which he afterward chose for his life work.

His early education was obtained in the common schools of Ohio, supplemented by two years' attendance at the Jefferson Academy, located at Jefferson, Ohio. At the age of eighteen he entered the Cleveland Medical College, now the medical department of the Western Reserve University. In the interval between the annual courses of lectures he taught school. He was graduated Doctor of Medicine in the spring of 1854, being the youngest member of his class, and himself a few weeks under twenty-one years of age. Even as a medical student he became convinced that the existing course of study was too short by at least two years to properly equip one for the practice of medicine, and as early as 1854 he placed five years as the proper minimum of time. He always stood for the best

possible education of the man or woman who chooses medicine as a vocation.

In December, 1855, called to Mendota from Ohio by the serious illness of his father, who, together with his brothers, William, David and John, had come west in the previous year, he began the practice of medicine in the place which was to be the scene of his life work. His father, Dr. W. J. Cook, died in Mendota in 1871.

On November 11, 1856, he was united in marriage with Catherine Morrison, of East Springfield, Ohio. Of this union there were born eleven children, Virginia, Charles E., James, John George, Albert, William Frederick, Edgar P., Wells Morrison, Kathrine and two sons who died in infancy. Two sons, James and John, died in



Dr. E. P. Cook.

early childhood. George died in 1886, and Will in 1890. His wife, Catherine Morrison Cook, died June 30, 1902, preceding him in death just four months. Two brothers survive him, Wm. F. Cook, of Mendota, and David A. Cook, of Ottawa, Illinois.

During the Civil War he responded to the call of Gov. Yates, took the examination at Springfield, and was appointed a surgeon in the service of the State of Illinois. Just after the battle of Shiloh he was ordered to the field near Corinth, Mississippi, and for six weeks was surgeon in charge of a regiment of Illinois Volunteers.

From the first of his medical career Dr. Cook identified himself with the general interests of his profession. He early joined the Illinois State Medical Society, and was always active in its affairs. In 1879 he was elected President. At the time of his death he was Chairman of the Judicial Council of the State Society. He was one of the early Presidents of the LaSalle County Medical Society, twice President of the North



Central Illinois Medical Association, and a member of the American Medical Association, the Association of Railway Surgeons, the American Public Health Association, and other medical societies. He was an honorary member of the Physicians' Club of Chicago. He was a delegate to the ninth International Medical Congress in Washington in 1887, and again in 1890 to the tenth International Medical Congress in Berlin, Germany.

First of all, Dr. Cook was a physician. He was an enthusiast in his profession to the day of his death. He was one of the earlier group of Illinois physicians. He was always progressive, and although a general practitioner in a small country town, it was his constant endeavor to keep abreast with the advances in medical science. His attention was particularly attracted to the surgical aspects of medical practice. While still a young physician he performed the first successful laryngotomy for tumor of the larynx which was done in the West, and also one of the early operations for ectopic gestation successfully made in this country. He was for many years the local surgeon of the Illinois Central and Burlington railroads. His acquaintance in his profession was unusually wide, and he took great delight in the professional friends he had made in his nearly half century of active medical practice.

As a citizen of Mendota, Dr. Cook's home paper speaks of him as follows: Dr. Cook was ever active in promoting what he considered the best interests of his home community. Questions which concerned the educational and sanitary interests of the community especially appealed to him. He was for many years President of the Public Library Board and of the Mendota Cemetery Association, two interests to which he gave special attention during the last years of his life.

In 1895, while continuing in the active practice of his profession, he served as a member of the City Council. He made a close study of the sewerage problem confronting cities which are situated like Mendota on the prairies of Illinois, and to his efforts were largely due the adoption and construction of the present sewer system of Mendota. In the course of this work he made a special trip to the East and investigated the sewer systems of a number of the smaller towns and cities which were pioneers in meeting this sanitary problem. His last public service was the earnest advocacy of a reorganization of the public school system of Mendota, and the establishment of a township high school. He was a school trustee at the time of his death. For several years he has been a Director and Vice-President of the Mendota National Bank. He was a member of the Mendota Lodge of A. F. & A. Masons, of the Mendota Chapter and of Bethany Commandery of the Knights Templar.

Dr. Cook joined the Methodist Episcopal Church in early life, and was one of the original trustees of the Mendota Church, a position which he continued to hold without intermission until the day of his death. His church membership was not a nominal relationship to him, but he ever exhibited a great interest in all that pertained to the spread of Christian faith and

influence and to the building up of power and usefulness of his own denomination.

He was for several years a director of the Illinois Children's Home and Aid Society, and one of the last acts of his life was to attend a meeting of the directors of the society in Chicago the day before his death.

For years he has taken so great a part in the activities of the church that those who have been associated with him feel that they have been unusually bereft. His last special work for the church was as Chairman of the Building Committee during the recent rebuilding of the church. In this work he took great interest and pleasure, and much of the credit for its successful completion must necessarily be accorded to him. The beautiful figure window in the church was his gift as a memorial for his beloved wife and himself. His selection for this purpose of the famous painting by Gabriel Max of "Christ and the Sick Child" was peculiarly fitting.

In March, 1900, while returning at night from a consultation visit in a neighboring town, Dr. Cook was stricken on the train with an attack of angina pectoris. He was forced to abandon at once the active duties of his profession. His health gradually improved, and although he was never again able to resume his work as a physician the last two years of his life were devoted to many interests, less arduous in their demands but equally important in his view.

His death was due to a sudden attack of angina pectoris, and although not entirely unexpected by those familiar with his condition it came as a severe shock to the community and all who knew him.

The funeral services were held at the late residence at 2 o'clock Monday afternoon, November 3, and were conducted by his pastor, Rev. Fred D. Stone, assisted by Rev. J. R. Hamilton, of LaSalle, and Rev. Theo. H. Allen. The pallbearers were physicians, W. O. Ensign, of Rutland; D. H. Law, Dixon; J. W. Edwards, Mendota; F. O. Robinson, Wyandot; J. F. Percy, Galesburg, and E. W. Weis, Ottawa.

Among his professional friends who were present were the following physicians: E. T. Goble and F. A. Wiley, Earlville; T. H. Stetler, Pawpaw; E. S. Murphy, Dixon; P. M. Burke, LaSalle; A. E. Owens, Princeton; N. F. Felker, Amboy; W. R. Owen, Sublette; Mosher, Troy Grove; E. L. Watts, Triumph, and R. M. Gordon, Arlington.

The interment was in Restland Cemetery.

On behalf of the Committee.

O. B. Will.

## State Items.

### THE JUDICIAL COUNCIL.

Galesburg, Ill., November 25, 1902.

Geo. N. Kreider, M. D., Editor Illinois State Medical Journal, Springfield.

Dear Doctor: You asked me some time ago to give you an abstract from the minutes of the Judicial Council following each of the meet-

ings of the Council for publication in the Journal of the State Society. It is difficult to do this from the fact that so many things are referred to the Council and their decision cannot always be published except to the parties most interested.

Our last meeting was held in Chicago, October 9, 1902. The meeting was called to order at 10:30 A. M. by Chairman E. P. Cook,\* Sr., of Mendota.

Members present were Chairman Cook, Vice-Chairman Ensign, Drs. Reat, Will, Graham, Mitchell, Black and Percy. President Harris of the State Medical Society was also present.

The first order of business after the reading of the minutes was the report by the Secretary that he had received from Secretary Weis a pamphlet entitled—"A Plan for the Study of Man," by Arthur McDonald, Washington, D. C. The pamphlet contained a resolution which if adopted would put the State Medical Society on record as favoring the establishment at Washington of a laboratory for the study of the criminal, pauper and defective classes. Dr. Ensign moved that the matter be referred to the officers of the State Society. Carried.

"The Kyger Resolutions for the Abolition of the Newspaper Publication of Personal Medical Advertisements," referred to us by the State Society at the Quincy meeting and left over from the last meeting of the Council, was taken up and considered. Dr. Black moved the following resolution as the sense of the Judicial Council on this important matter:

"Resolved: That after due consideration we recommend 'The Kyger Resolutions for the Abolition of the Newspaper Publication of Personal Advertisements' to the State Society for its adoption. Be it further

"Resolved: That we recommend to the Illinois State Medical Society that a permanent committee be appointed by the President of the State Society to investigate the whole question of the prevention of conception and the production of criminal abortion." Carried.

Dr. Black asked permission of the Chair to bring up the question of the payment of the expenses incurred by the Legislative Committee. Dr. Ensign volunteered the information that the House of Delegates made no financial provision at the Quincy meeting for the conduct of the business affairs of the State Society. Dr. Black stated that he found this to be true when he sent the bill for the expenses of his committee to President Harris and Secretary Weis for their approval before presenting it to the Treasurer, Dr. Brown of the State Society for payment. President Harris called attention to the fact that the only way the matter could be adjusted was as provided in Chapter 8, Section

4, of the new Constitution. The matter was finally adjusted by the adoption of the following:

"Resolved: That the Legislative Committee be and is hereby authorized to expend any amount not to exceed five hundred dollars (\$500) for the necessary expenses of the work during the coming year and that the bills presented by the said committee be paid by the Treasurer after approval by the auditing committee."

The next order of business was the report of the Chairman of the committee appointed by the Council to confer with the Chicago Medical Society. The Chairman of this Committee, Dr. Graham, was present and gave a verbal report of what had been done to date. As nothing up to this time had been definitely accomplished, the committee was continued. Dr. Ensign introduced the following resolution which was carried:

"Resolved: That the special committee of the Judicial Council of the Illinois State Medical Society appointed to confer with the Chicago Medical Society relative to the publishing of the transactions of the latter in the Illinois Medical Journal be recommended to secure if possible a duplicate copy or abstract of such transactions for publication in said Journal, until the annual meeting of the State Medical Society in May, 1903."

Dr. Black, Chairman of the committee for the incorporation of the State Society stated that his committee was not yet ready to report as to what they had done toward accomplishing this work.

Resolved: That the Publication Committee be empowered to at once employ a solicitor of advertising for the Journal, such agent to be paid a liberal commission from the amount of cash actually received by the Journal from his contract.

The following was also acted upon favorably:

"Resolved: That the Secretary of the Illinois State Medical Society be instructed to send the Journal for the sum of one dollar from Dec. 1st, to May 1st, to all members of the local societies in affiliation with this society, not now members of the State Society, but who shall make application to become members of the State Society, such applications to take effect at the next annual meeting."

This resolution was also introduced and carried:

"Resolved: That the Judicial Council believes that if members of all local societies in affiliation with the State Society become contributing members of the State Society, the Journal can be issued bi-weekly and made to contain a digest of the meetings of all affiliated societies as well as the transactions of the Illinois State Medical Society and further, that if each member will lend his influence to securing advertisements for the Journal, the amount of the annual dues can be greatly reduced."

The Judicial Council authorized Secretary Weis of the State Society to issue certificates of membership to the following societies in the

\* Dr. Cook presided at this meeting in his usual place as Chairman. He exhibited all of his old time interest in the questions that were before the Council for decision and settlement. Indeed he seemed to be in better health than at any previous meeting of the Council for some time. His sudden death at his home in Mendota, October 31, came as a severe shock not only to the Council but also to those members of the profession in the State who had known of his sterling worth for so many years. It was in the Council however that the sterling qualities of mind and heart which Dr. Cook possessed, showed to best advantage. In him was every essential of the good physician and as well, the true characteristics of an honorable man.  
J. E. Percy, Sec.



State who had applied for them. The following is a copy of the letter sent to Dr. Weis:

October 20, 1902.

Dear Doctor Weis: Enclosed please find the applications sent to the Judicial Council by you of the following named societies who have applied for recognition by the State Society under the new Constitution, and which have been acted upon favorably by the Council: (See report of Secretary Weis.)

The application of the Jackson County Physicians' Protective Association was also approved but with the recommendation that it strike out the word "Protective" in its chartered title, for the reason that this word does not harmonize well with the aims and objects of a scientific organization and in addition is liable to be (as it has been) misinterpreted as to its meaning by the profession outside of Jackson County.

The application of the Aux Plains Medical Society is referred back with the request that the Judicial Council be given information as to the boundaries of the territory embraced by their organization.

The application of the Western Illinois District Medical Society was also approved, together (by request) with the change of name from the Medical and Surgical Society of Western Illinois. The following is a copy of the letter to Secretary Weis asking for the change:

Whitehall, Ill., Sept. 6, 1902.

Dr. E. W. Weis, Ottawa, Ills.

Dear Doctor: At the last meeting of the Medical and Surgical Society of Western Illinois, we changed the name and adopted a new constitution and by-laws to conform with the State Constitution.

Our present name is "Western Illinois District Medical Society."

Will our application for affiliation under the former name hold good for this? We desire that it should. I think that we should be classed among the district societies and our president should be a vice-president of the State Society. We have worked very hard to maintain and enlarge this Society and are growing. An early reply will oblige.

Yours very respectfully,

(Signed.) H. A. Chapin, M. D.

The application of the Aesculapian Society of the Wabash Valley, approved.

The application of the tri-county societies (comprising Vermilion, Iriquois and Ford Counties) was referred back for correction in their organization and name. The reason for this is that Vermilion County is already organized and has applied for recognition as the Vermilion County Medical Society. The two remaining counties (Ford and Iriquois) can organize by hyphenating the names of the two counties just mentioned. When this is done the Council recommend that their application be approved.

The application of Schuyler County was also approved and with the approval the recom-

mendation was made that the Secretary of the State Society refer the fact of the small membership of this Society to Chairman Dr. Hall of the Committee on Medical Societies to see if the membership cannot be increased.

It was also ruled (unanimously) by the Judicial Council that all special and local societies in any county in the State were but subsidiary organizations to the county society and that they must seek representation through affiliation with their respective county organizations.

Minutes continued: The status of affairs politically in the 32d Senatorial district was next referred to. After much discussion the Secretary was instructed to learn the wishes of the physicians in that district and also to see the leaders of Mr. Berry's political party, both of which instructions were carried out. As a result the following letter was sent out:

October 31, 1902.

Dear Doctor: Mr. Berry has made a favorable reply to the letter sent you about two weeks ago as to his future attitude toward the medical profession. In addition to this, some of his political friends who are high in the councils of the Republican party in the State have authorized the use of the following: "That Mr. O. F. Berry of Carthage, Illinois, in the event of his election, has given satisfactory assurance through his friends that he will not oppose such legislation as may be desired by the Illinois State Medical Society."

Sincerely,

(Signed.)

J. F. Percy, Secretary.

About the same time Mr. Berry sent out the following:

Carthage, Ill., Oct. 28, 1902.

Dear Sir: There has been during the campaign, considerable controversy and considerable letter writing in reference to my position towards the medical profession. I have taken some pains to set the matter right and I feel now, that in view of the situation as it now stands and the information that all physicians must have as to the real situation and to my position, that I am at least, entitled to the support of every physician in my own party. I do not know the politics of every physician in this district, but I feel that every physician, having now fully investigated the matter, surely has sufficient proof before him to justify him in supporting me, and whatever may be your politics, I would be glad of your support, and assure you that you will have no occasion so far as I am concerned, to regret it.

Very respectfully yours,

(Signed.)

O. F. Berry.

Sincerely,

(Signed.)

J. F. Percy, Secretary.

#### Societies Approved by Judicial Council.

Editor Journal:—The following named Societies that have made application to be recognized as branch societies have been ap-



proved by the Judicial Council:

Adams County.	Massac County.
Alexander County.	McDonough County.
Bond County.	McLean County.
Bureau County.	Mercer County.
Calhoun County.	Montgomery County.
Carroll County.	Morgan County.
Clay County.	Ogle County.
DeWitt County.	Pike County.
Douglas County.	Perry County.
Edwards County..	Pope County.
Fulton County.	Pulaski County.
Gallatin County.	Richland County.
Greene County.	Sangamon County.
Grundy County.	Schuyler County.
Hancock County.	Stark County.
Henderson County.	St. Clair County.
Jersey County.	Tazewell County.
Jo Daviess County.	Union County.
Johnson County.	Vermilion County.
Kendall County.	Warren County.
Knox County.	Winnebago County.
La Salle County.	Will County.
Lake County.	Williamson County.
Livingston County.	White County.
Macoupin County.	Wabash County.
Marshall County.	

The Fox River Valley Medical Society for Kane County.

The Peoria City Medical Society is approved for Peoria County.

It was also ruled unanimously by the Judicial Council that all special and local Societies in any County in the State were but subsidiary organizations to the County Society, and that they must seek representation through affiliation with their respective County organization.

The following District Medical Societies are approved:

- Aesculapian Society of the Wabash Valley.
- Brainard District Medical Society.
- District Medical Society of Central Illinois.
- Galva District Medical Society.
- Military Tract Medical Society.
- Southern Illinois District Medical Society.
- Western Illinois District Medical Society.

Official. E. W. Weis, Secretary.

#### Meeting of the Executive Committee.

The Executive Committee was called to order at the Chicago Athletic Association rooms, Chicago, Nov. 20th, by President M. L. Harris. On roll call those present were M. L. Harris, J. H. Stowell, George N. Kreider, L. C. Taylor, W. E. Schroeder and E. W. Weis. Absent, W. K. Newcomb.

The following preamble and resolution was offered by Stowell seconded by Taylor and carried unanimously:

"Whereas, the meeting of the American Medical Association for 1903 to be held in the city of New Orleans takes place one month earlier than usual and prior to the date heretofore designated by the Illinois State Medical Society for its next meeting and

Whereas, if the Illinois State Medical Society is to be represented at this meeting of the American Medical Association, it must elect its delegates at a prior date to said meeting. It therefore becomes necessary to change the date of said meeting of the Illinois State Medical Society. Therefore be it

Resolved, by the Executive Committee of the Illinois State Medical Society for the above good and sufficient reasons that the date of the next general meeting of the Illinois State Medical Society be changed from the date before named and that the said meeting be held on April 29th, 30th, May 1st, and 2d, 1903."

The Committee of Arrangements reported that it had secured Tremont Hall, corner Lake and Dearborn streets, for the use of the Society at its next meeting. Report adopted.

It was ordered that the session of the next general meeting shall convene on Wednesday, April 29th, 1903, at nine o'clock A. M. and after canvassing the subject thoroughly it was moved and carried that the forenoons of the session shall be given to the reading and discussion of papers and that the afternoons of each day shall be devoted to attending the various clinics that will be specially given for the members of the Society at the different hospitals. The evenings of the first and second days shall be devoted to the delivery of the addresses of the president and orators of the sections. On Friday evening the Committee of Arrangements and the profession of the city of Chicago will entertain the members of the Society.

The House of Delegates for the transaction of business shall convene on Wednesday, April 29th at two P. M. and continue in session the afternoon of the 30th and of May 1st.

It was moved and carried that the officers of Section three be instructed to secure orator outside of Chicago and in the State.

Moved and carried that the officers of Section one and two be instructed to secure the orators of their sections.

It was moved and carried that the details of the entertainment for Friday evening be left to the Committee of Arrangements.

It was suggested that the Sherman House be used as headquarters during the session.

It was moved and carried that the Committee of Arrangements be instructed to send out an invitation on behalf of the Illinois State

Medical Society to the general profession of the State inviting the profession to attend the next meeting of the Illinois State Medical Society, said invitation to be sent out one month prior to the date of said meeting.

Adjourned subject to call of president.

E. W. Weis, Secretary.

## Correspondence.

### The Chicago Drainage Canal.

To The Editor:—

Because of the wide prevalence of typhoid fever in the city of Chicago during the past few months, the Chicago Drainage Canal, otherwise known as the Chicago Sanitary and Ship Canal, is now receiving unusual attention.

This artificial channel, which extends southeasterly twenty-eight miles down the valley of the Desplaines River, from a connection with the south branch of the Chicago River, six miles from Lake Michigan, has been variously called a "stupendous blunder," "the greatest sanitary mistake of the world," "a conspicuous failure," "an unsuccessful undertaking," etc., etc., for no other apparent reason than that it fails to purify the water supply of the city of Chicago.

The drainage canal has been termed one of the greatest engineering projects of the century; it would certainly be an engineering project such as the wildest imagination could scarcely conjure if it purified the water supply of Chicago under the conditions now existing.

It must not be forgotten that at the present time the sewage of at least 400,000 inhabitants of the North and South Sides of the city of Chicago drains directly into Lake Michigan. Through the failure of the city to complete its intercepting sewer systems, this sewage is not turned into the canal, which is there to receive it.

All the storm water from the territory which is to be drained by the intercepting sewers also flows directly into the lake. This causes a frequent flushing of the sewers, and during and after heavy rains the large flow of water through the sewers forces the sewage out in the lake toward the cribs, thus directly polluting the water supply. For the existence of these conditions the Chicago Drainage Canal certainly should not be held responsible.

The canal as completed fulfills the purposes for which it was designed. No one can take exception to the statement that it is feasible to divert the entire sewage of the city of Chicago into the canal via the Chicago River. The investigations conducted by the Illinois State Board of Health have conclusively shown that the sewage and industrial wastes of a population far in excess of that of the city of Chicago can be carried through this canal into the Desplaines and Illinois Rivers without detriment to the people of the Illinois Valley.

On the completion of its intercepting sewer systems, the city of Chicago will ordinarily

have access to an unlimited supply of water free from any material organic pollution other than that which may be caused by the sewage from the Calumet region south of Eighty-seventh street and the cities of Illinois on the shore of Lake Michigan north of Chicago. While a consideration of the dangers from these sources involves a careful study of lake currents, both surface and deep, wave action and the rate of sewage purification in large bodies of water, it certainly would appear that this sewage cannot be permitted to drain into Lake Michigan unless first subjected to satisfactory preliminary treatment.

Unless filtration is resorted to every municipality on the lake shore will need, for its own protection at least, to either purify its sewage before emptying into the lake, or otherwise dispose of it.

The diversion of all the sewage from the important towns immediately north and south of Chicago into the drainage canal has been advocated by the Sanitary District of Chicago. By competent engineers this project has been pronounced feasible, and it is safe to prophesy that in the event of its consummation there will be no further anxiety concerning the purity of the water supply of Chicago.

In conclusion, it may not be out of place to call attention to the fact that the Chicago Drainage Canal owes its existence to the investigations and deliberations of the Drainage and Water Supply Commission of Chicago, which is said to have been the only scientific body that ever made a comprehensive study of the sanitary features of the Chicago region. This Commission was composed of three men well-known to sanitarians, Rudolph Hering, Benzette Williams and Samuel Artingstall, each one of whom was pre-eminent qualified to perform the duties devolving upon him.

After a year's labor, in 1886 the Commission reported that among the methods of disposal of the sewage but three had been deemed worthy of an extended consideration, viz: a discharge into Lake Michigan, a disposal on land by filtration and irrigation, and a discharge into the Desplaines River. The Commission was strongly in favor of the method of disposal on land, but it was shown that not only was it impracticable to obtain the required land within the borders of the State, but that the initial cost of this project would be prohibitive—nearly double the amount already expended in the construction of the drainage canal. The Commission recommended as the most feasible plan, and one of the least expensive at that time as well as in the future, the discharge of the sewage into the Desplaines River. This recommendation was directly in accordance with that made by Dr. John H. Rauch in his first report to the Illinois State Board of Health on the subject, viz: "The removal of her (Chicago's) sewage properly diluted by the water course flowing towards the Mississippi." In a subsequent report, made prior to the report of the Commission, Dr. Rauch termed this the best, if not the only feasible plan.

J. A. Egan,

Secretary Illinois State Board of Health.  
November 17, 1902.



## New Incorporations.

New corporations have been licensed by the Secretary of State at Springfield during November as follows:

Kewanee Public Hospital Association, Kewanee; not for profit, treatment and care of the sick and injured; incorporators, Elizabeth A. Fleming, Emily Lyle, Rhoda A. Hepo.

The Winthrop Drug and Chemical Works, Chicago; capital, \$150,000; manufacturing drugs and chemicals; incorporators, William H. Edgar, Robert F. Carr and Charles M. Eddy.

The Chicago Correspondence School of Nursing, Chicago; capital, \$2,500; educational; incorporators, W. H. Webster, Ester E. Webster and Charles T. Murphy.

Northern College of Dental Surgery, Chicago; capital, \$2,500; educational; incorporators, Frank F. Tollkuehn, Alonzo D. Radcliffe, Elgin F. Neal.

The Cold Go company, Chicago; capital, \$25,000; manufacturing drugs and medicines; incorporators, William B. Martin, Cherry Moulton, and Martin T. Baldwin.

The Doctor Pratt institute, Chicago; capital, \$1,000; furnishing medical and surgical treatment; incorporators, Arthur W. McCovney, Eli Moses, and Johan Waage.

## Local Societies.

**The Mason County Medical Society.** Just as the Journal goes to press information comes that the physicians of Havana and Mason County are arranging to form a Society. Doubtless this organization will be completed before the next issue.

**The Southern Illinois Medical Association** met at Centralia, Thursday and Friday, November 6 and 7. About sixty physicians were in attendance. The new officers elected were: President, J. A. Helm, Metropolis; Vice-President, M. D. Empson, Hartford; Second Vice-President, J. W. Armstrong, Centralia; Secretary, E. E. Fyke, Centralia; Treasurer, A. T. Telford, Olney. Marion, Wilson County, was selected as the next place of meeting.

E. E. Fyke, Official Reporter.

**The Cass County Medical Society** was organized at Virginia, November 6, 1902. The officers are: J. A. Glenn, of Ashland, President; George Bly, Jr., Beardstown, Vice-President; J. A. McGee, Virginia, Secretary; J. G. Franken, Chandlerville, Treasurer. The organization is complete, adopting the Constitution and By-Laws as promulgated by the National Association, and starts out under flying colors. Time of meeting, first Wednesday of each month at 2 p. m.; place to be decided from time to time. The members are: C. M. Hubbard, George Bly, Jr., A. R. Lyle, A. J. Palmer, J. K. Elder, W. D. Humphry, Walter Bly, J. G. Franken, R. H. Garm, T. J. Schweer,

J. A. McGee, L. M. Sinker, J. A. Glenn, E. A. Knodle, C. J. Koontz, and H. B. Boone.

J. A. McGee, Official Reporter.

**The Marion County Medical Society.**—About eighteen Marion County physicians participated in the organization of a County Medical Society in Centralia, Friday, November 7. The following officers were elected: President, A. P. Kell, Kell, Ill.; Vice-President, S. D. Tracey, Odin, Ill.; Secretary, E. E. Fyke, Centralia, Ill.; Treasurer, W. W. Murfin, Patoka, Ill. The Society adjourned to meet at Centralia the first Saturday in December, when a scientific program will be presented.

E. E. Fyke, Official Reporter.

**The Peoria City Medical Society** met in regular session October 28 for the annual election of officers. The meeting was called to order by the President, M. S. Marcy. The following officers were elected for the next year:

Robert A. Hanna, President; L. A. McFadden, Vice-President; H. M. Sedgwick, Second Vice-President; Jeannette Wallace, Treasurer; C. U. Collins, Secretary.

C. U. Collins, Secretary.

**The Peoria City Medical Society** met November 4 at the National Hotel. The Society was called to order by the President, M. S. Marcy, who, in a neat speech, introduced Robert Hanna, the President-elect, who, after a brief address, assumed the duties of President.

After the transaction of the regular business, the Society listened to a very interesting paper by Frederika Zeller, entitled "Medical Gleanings in Europe and the Far East," and illustrated by lantern slides. It was moved, seconded and carried unanimously that a vote of thanks be extended to Dr. Zeller for the instructive and entertaining paper she had presented to the Society.

The members present were: Drs. Hanna, McFadden, Sedgwick, Wallace, S. M. Miller, Waln, Lucas, Eckard, Roberts, Will, Roskoten, Hensley, Stephenson, Allison, G. A. Zeller, Whiting, Finnell, Marcy, Bradley, Green, Hayes, E. L. Davis, J. S. Miller, F. Zeller and Kanne.

C. U. Collins, Secretary.

**The Peoria City Medical Society** met in regular session November 18, 1902, at the National Hotel, and was called to order by President Hanna.

A letter was read from Chairman Carl Black of Jacksonville. J. W. Hensley moved that the letter be received and placed on file, and that the Society give \$25 for the use of the Committee on Medical Legislation. This motion was seconded and carried.

R. A. Hanna, the newly elected President, was the essayist for the evening. He urged the members to report their cases, and particularly their errors as well as their successes. He read an excellent paper on *Delirium Tremens* which was fully discussed by Drs. Roberts, Kerr, C. E. Davis, Sutton, Marcy, Green, Hensley, Lucas, Kanne, Hayes and Roskoten.

During a discussion on the relation of the coroner to the physicians, E. M. Sutton introduced Mr. B. M. Chipperfield, States Attorney



of Fulton County, and a member-elect to the legislature, who made an excellent and instructive talk concerning our relations to the corner, and assured the Society of his support of any needed legislation brought to his notice by them.

J. W. Hensley moved that a vote of thanks be extended to Mr. Chipperfield for his remarks and his statement concerning his policy in the legislature toward measures affecting the medical profession. This motion was carried unanimously.

The members present were R. H. Hanna, C. E. Davis, McFadden, E. Franc Morrill, Jeannette C. Wallace, Kanne, Marcy, Hensley, Sutton, E. L. Davis, Eckard, Plummer, Waln, Weber, Roberts, Lucas, Kerr, Will, Stephenson, Roskoten, Hayes, Green and S. M. Miller.

C. U. Collins, Official Reporter.

**The Livingston County Medical Society** held its fourth semi-annual meeting in Pontiac, November 6. Twenty-five members were present, including six new applicants, who were admitted by unanimous ballot.

James Mitchell presented an interesting case of **splenic leukaemia**, and Normal Pearson showed several slides of blood from the case under the microscope. V. M. Daly read a paper on "**Injuries to the Vagina in Primipara During Labor**," and E. E. McCoy, of Flanagan, read a paper on "**Nasal Catarrh in Children**." G. C. Lewis, of Fairbury, gave an address on "**The Reminiscences of a General Practitioner**," and A. C. Cotton, of Chicago, gave an exhaustive address on "**Typhoid Fever in Infancy and Childhood**." The physicians of Pontiac tendered a banquet to the visiting physicians, and the Vermillion Club gave a smoker in honor of the Society. Burch's Orchestra, of Fairbury, furnished music during the banquet and evening program. This meeting was one of the best ever held by our Society, and the social feature on our programs hereafter will be one of the things to which we will pay marked attention. Drs. Mammen, of Bloomington, and Cotton, of Chicago, helped to make the meeting a great success.

John Ross,  
Official Reporter.

**The Mercer County Medical Society** met in regular session October 14, 1902, in the Methodist Episcopal Church at North Henderson. There was an excellent attendance and a fine spirit throughout, both morning and afternoon sessions.

M. G. Reynolds, President, called the house to order at 10:30 a. m. When the minutes of the previous meeting was read and approved, the applications of J. D. McMillan, J. D. McKelvy, H. H. Sherwood, A. C. Cells, J. M. Wallus, J. S. Allen, H. S. Allen, J. W. Ramsey and L. B. Doxey were presented to the Board of Censors.

The temporary Board of Censors reported favorably on all except L. B. Doxey. The name of L. B. Doxey was allowed to remain for action of the permanent Board of Censors.

A communication from Carl E. Black was read and discussed freely. It was moved that the proposed "**Medical Bill**" be accepted as a whole, but that the lines 17, 18, 19, page 21, be

rejected, and that instead of reading, "**The same to be recovered in an action of debt before any court of competent jurisdiction**," to read, "**The same to be considered as a felony, and punishable by imprisonment until such fine shall be paid**." The same to be enforced by any court of competent jurisdiction."

Moved that the members of this Society be asked to correspond with our Representatives and urge them to use their influence for the enactment of said bill as amended.

A paper on "**Appendicitis**" by V. A. McClanahan, of Viola, and one on "**Physiological Therapeutics**," by H. H. Sherwood, of New Windsor, were read and discussed, many points being presented.

Adjourned to meet in Aledo, Ill., the second Tuesday in January, 1903.

A. N. Macky, Official Reporter.

**The Vermillion County Medical Society** held its annual meeting Nov. 10th, in the city hall, called to order by the President, J. M. Guy.

The names of S. W. Landaur, Francis Barton and Benjamin Gleeson were presented for membership and handed to the board of censors.

The annual report of the treasurer was read and accepted.

The question of admitting other than graduates of regular medical schools was discussed and a motion that none such be admitted was carried.

The paper of the evening was on **Chronic Cystitis** in the male by J. G. Fisher of Catlin which brought out a general and interesting discussion.

Election of officers as follows: President, H. F. Becker; Vice-President, F. N. Cloyd of Westville; Secretary and Treasurer, E. E. Clark, re-elected.

The president appointed the following board of censors, C. E. Wilkinson, J. M. Guy and T. E. Walton.

The old committee on violations of the Medical Practice Act was retained consisting of Joseph Fairhall, E. E. Clark and T. E. Walton.

A motion to send \$25.00 to the chairman of the Legislative Committee was carried and the Secretary instructed to forward the amount.

There being no further business the Society adjourned to the December meeting.

E. E. Clark, Official Reporter.

**The Henry County Medical Society** was organized at Cambridge, Tuesday, October 7, 1902. L. A. Ferry, Geneseo, was made President for the ensuing year; W. H. Cole, Kewanee, Vice-President; H. W. Waterous, Galva, Secretary; and J. A. Kirkland, Cambridge, Treasurer.

The "Model" Constitution and By-Laws, as published in the Journal of the American Medical Association, with some modifications, were adopted.

It was decided to hold annual meetings at Cambridge the first Tuesday in September.

The papers read at this meeting were:

The X-ray ..... L. A. Ferry  
Prostatotomy ..... C. S. Young  
Massage ..... J. E. Westerlund

The following now constitute the Society: J. A. Kirkland, J. E. Westerlund, Cambridge; L. A.

Ferry, C. S. Young, F. W. Carman, Geneseo; H. N. Heflin, C. W. Hall, Kewanee; J. F. Vannice, Bishop Hill; H. W. Waterous, Galva; F. O. Ringnell, Orion.

H. W. Waterous, Official Reporter.

The Crawford County Medical Society held a regular bi-monthly meeting at the office of Drs. Rafferty & Rafferty, Robinson, Ill., Nov., 1902. J. B. Cato, president in chair. Members present: T. N. and H. N. Rafferty, Barlow, Voorheis, Price, Hoskinson, Dunham, Hayhurst, A. G. Meserve, McGowin, Birch, Cato and Cooley. The names of G. W. Fuller, Jas. R. Wattleworth and J. W. Montgomery were presented for membership. The rules were suspended and they were duly elected to membership.

C. Barlow presented a well prepared paper on the "Management of Typhoid Fever," which was thoroughly discussed by members and visitors.

C. H. Vorheis read a paper "Animal Cell Extract as a Therapeutic Agent" with report of case of Nephritis treated as above with complete recovery. Society much interested in subject and further investigation and observation promised. The Society adopted the following resolution:

"Resolved, That the Crawford County Medical Society does hereby endorse the action of the legislative committee of the Illinois State Medical Society, and take this manner to personally recommend the bill of the committee, and in every way, financially if necessary, to enable them to pass the bill they recommend."

The Society adopted the following resolution: "Resolved, That the Crawford County Medical Society contribute the sum of ten (\$10) to the legislative committee and the treasurer be ordered to remit same."

Society adjourned to meet the second Thursday of January 1903.

E. M. Cooley, Official Reporter.

The Sangamon County Medical Society held its regular and annual meeting Monday evening, November 10, 1902, at 8 o'clock, in the Leland Hotel. There were thirty-five members in attendance. The meeting was called to order by the President, L. C. Taylor. The minutes of the October meeting having been read and approved, the next order of business was the election of officers for the coming year.

For the office of President, A. L. Brittin was nominated. There being no further nominations, the Secretary was authorized to cast the ballot for the Society, and A. L. Brittin was declared elected for the ensuing year.

For the office of Vice-President, B. B. Griffith was nominated. There being no further nominations, the Secretary was instructed to cast the ballot for the Society, electing him for that office.

For the office of Secretary, P. L. Taylor was nominated. There being no further nominations, the President was instructed to cast the ballot for the Society, declaring him elected for the coming year.

G. N. Kreider offered the following amendment to the Constitution: "That the office of

Secretary-Treasurer be hereafter vested in one person." After the amendment is passed, the Treasurer will be elected.

For the Board of Directors, O. B. Babcock, G. F. Steriker and S. E. Munson were nominated. There being no further nominations, the Secretary was instructed to cast the ballot for the Society, electing them as members of the Board of Directors.

The application of N. R. Gordon, with the usual fee, was read and referred to the Board of Directors. The Treasurer was instructed to pay the Secretary \$1 (one dollar) for each meeting in which he has acted as Secretary. The bills of N. B. Wiggins, Phillips Bros., and Secretary were ordered paid.

There being no further business, the Society adjourned to the banquet hall, which had been beautifully decorated and arranged for the occasion. After enjoying the well selected menu, the Society was delightfully entertained with the following toasts, L. C. Taylor acting as toastmaster:

Specialists and Specialism ..... B. B. Griffith  
The Practice of Medicine in the Past.....

..... A. L. Brittin  
The Practice of Medicine in the Future ....

..... R. D. Berry  
The Physician in Politics ..... G. N. Kreider

The Physician as a Friend ..... M. T. Shutt  
The Physician as a Dreamer.....

..... O. B. Babcock

This was the second annual banquet and the commencement of the fourth year for the Sangamon County Medical Society. Indications are good for interesting and beneficial meetings during the coming year. It is the earnest desire of the officers that each member will assist in every way possible to make the coming year as helpful as the past.

Percy Louis Taylor,  
Official Reporter.

The Southwestern Medical Society held its twenty-third regular meeting at Grace Cafe, 540 West Sixty-third street, Chicago, Tuesday evening, September 9, 1902. Vice-President Hagey was in the chair, and after the usual lunch, we proceeded with the business of the evening; viz, election of officers.

T. C. Eggert was declared elected president.

F. C. Wier was then nominated and unanimously elected Vice-President.

C. Hubart Lovewell was placed in nomination to succeed himself as Secretary, and was unanimously elected.

Dr. Eggert then took the chair and proceeded to conduct the affairs of the meeting.

The President appointed a committee to arrange for our annual banquet, to be held in January, 1903.

T. C. McGonagle moved that a per capita tax be spread of 50c per annum to cover a deficit in treasury. Carried.

Dr. Eggert then appointed on the Banquet Committee, Drs. Green, Davis and Rose.

Dr. Cuthbertson then made a few remarks upon the subject of perineorrhaphy.

Attendance, 24.

The twenty-fourth regular meeting was held at Grace Cafe, Tuesday evening, October 14,



1902. Dr. Eggert in the chair.

The President made the following appointments:

Membership Committee: J. H. Hess.

Program Committee: Drs. Avery and Wier.

Official Reporter: T. C. McGonagle.

Drs. Lovewell and Bell were appointed a Sick Committee to visit Dr. Denham, who is ill in the Chicago Hospital.

Prof. Archibald Church was then introduced as the speaker of the evening, and he gave a most interesting and practical talk on, "**The Differential Diagnosis and Treatment of Cerebral Hemorrhage and Cerebral Thrombosis.**" Full and free discussion followed.

Attendance, 30.

The twenty-fifth regular meeting was called to order by President, Tuesday evening, November 11, 1902.

After the usual lunch, Prof. Arthur R. Edwards was introduced, and he gave a very learned talk on "**The Diagnosis and Treatment of Typhoid Fever.**" The subject was then very generally discussed.

Dr. Green made a detailed report of the Committee on reorganization and affiliation of our Society with the Cook County Society.

The report was accepted, and will be balanced on at our December meeting.

The report of the Banquet Committee was ordered laid on the table until the December meeting.

Attendance, 45.

Thos. C. McGonagle,  
Official Reporter.

The Morgan County Medical Society met in regular session on Thursday, October 9, 1902, at its rooms in the Hockenhull building, with president, P. C. Thompson, in the chair.

A. H. Flickwir, of Jacksonville, was unanimously elected to membership.

The following members were in attendance: J. G. Franken, of Chandlerville; Maness, of Nortonville; Miller, of Woodson, and Baxter, Bowe, Burkholder, Norbury, Reid, Thompson and Wakely, of Jacksonville.

Dr. Duffield, of Pittsfield, was invited to give an exhibition of his method of resuscitation in cases of asphyxia of the new born, at the November meeting.

Dr. Wakely was invited to exemplify the use of the St. Cyr Obstetric Tractor on the Manikin, at the same meeting.

Motion by D. W. Reid: **That this Society approve and endorse "the proposed bill for the regulation of the practice of medicine and establishing a board of medical examiners in the State of Illinois,"** subject to such amendment as may seem best. Motion seconded by Dr. Wakely and the motion prevailed.

F. P. Norbury reported a case of typhoid fever.

J. G. Franken reported a case of **appendicitis, with symptoms of typhoid fever.** The case was operated upon.

G. W. Miller reported a large number of cases of typhoid fever.

D. W. Reid reported some cases of typhoid fever, and made remarks on some features in treatment.

J. H. Wakely spoke on some of the features of treatment and diet in typhoid fever.

Edward Bowe discussed the early prognosis in typhoid fever, especially referring to those cases where there is early tympanites with toxæmia.

P. C. Thompson read a paper on "**Skin Diseases—Diagnosis.**"

Edward Bowe discussed at length the etiology, pathology and treatment of skin diseases and also reported a case of **erythema nodosum.**

F. P. Norbury continued the discussion on skin diseases, referring to acne, epithelioma and cancer treated with the X-Ray.

On motion the Society adjourned.

T. A. Wakely, Official Reporter.

The Winnebago County Medical Society held a meeting November 11, 1902. J. A. Egan, Secretary of the State Board of Health, was present and addressed the Society on "**State and Local Boards of Health; Their Powers and Limitations, and the Legislation Necessary.**" His paper, in substance, was as follows:

The Illinois State Board of Health, as a sanitary organization, operates under a law now over a quarter of a century old; obviously, this law needs revision.

As a medical examining and licensing body, the Board is organized under a law originally enacted in 1877, amended in 1887, and again amended in 1899, the latter two being new laws.

In common judgment, a law which has been amended twice in fifteen years, the last time but three years ago, ought to be satisfactory now. There is no doubt, however, that the Act of 1899 needs still further revision.

I. Let me touch on the Board as a sanitary organization.

It is charged with the general supervision of the lives and health of the people of the State and of its system of registration of vital statistics. It has charge of all matters pertaining to quarantine, and has authority to make such rules, regulations and investigations as seem necessary, and it is made the duty of police officers, Sheriff and other State officers, to enforce such rules. Seemingly, the powers conferred on the Board are almost unlimited, and the opinion of the Attorney General of the State inclines to this view.

II. As an examining and licensing board, it becomes the duty of the Board to determine the standing of all medical colleges, to examine and license physicians, midwives and persons who treat without drugs, to refuse to issue or to revoke certificates provided for in this act to persons found guilty of unprofessional conduct, and to prosecute persons violating the provisions of the Act. There is no question that the Board is clothed with ample power, and the constitutionality of the Act has been passed upon by the Supreme Court of the State. In short, the act, though defective in some parts, is one of the best medical practice acts in the United States.

### III Legislation Necessary.

At present there is no penalty for the violation of the rules and regulations of the State Board of Health. An act without a penal clause becomes practically inoperative. This defect



should be remedied. A section should also be added making it obligatory upon local Boards of Health, City Councils or Village Boards of Trustees to comply with the orders of the State Board of Health and give the State Board power, in case of refusal or neglect to comply with its orders, to enforce the same at the expense of the municipality.

#### A. Local Boards of Health.

Chap. 24, Sec. 62. Revised statutes confers upon City Councils and Boards of Trustees power to appoint a Board of Health and prescribe its powers and duties.

The law, however, is defective, in that the appointment of local Boards of Health is optional with the City Council or Village Board of Trustees. These bodies should be required to appoint a board, and the law should specifically state that whenever practicable a physician should be a member of the board. In too many cities of the State the duties of health officers are performed by a layman.

As to the present Medical Practice Act, the State Board of Health is a sanitary organization, as well as an examining and licensing body. For years I have entertained the opinion that the regulation of the practice of medicine should devolve upon a board separate from the State Board of Health. Legislation is called for creating a State Board of Medical Examiners to regulate medical colleges and examine and license physicians. Should the proposed bill creating a State Board of Medical Examiners become a law, these defects will have been remedied. Should it fail, the present act should be amended not only to cover the above defects but to provide for an Assistant Secretary to the Board. It is practically impossible for one man to properly perform the duties now required of the Secretary.

There is one other defect in the present Act. In Sec. 6 the Board is empowered to revoke certificates issued under the provisions of "this act." According to the opinion of the Supreme Court, the Board cannot revoke any certificates issued prior to July 1, 1899. Obviously, there should be an amendment giving the Board power over all certificates, whenever issued.

However, the Board of Medical Examiners, if created, will not have extraordinary powers in the matter of revocation of certificates, nor will it be able to rid the State of those practitioners who, in the opinion of the Board, seek practice by false or fraudulent representations, or who are guilty of conduct deemed unprofessional. This Board will have no greater powers in this matter than was conferred on the State Board of Health in the medical law of 1887, which in effect till 1899. During this time but few certificates were revoked.

The reason being found in the celebrated *McCoy-Denison* by the Supreme Court: "It (the revocation) must be for some act or conduct that would in common judgment be deemed unprofessional or dishonorable." That is in the judgment of laymen—a jury. That there can be no reflection on the State Board of Health for not revoking certificates is plain.

Dr. Egan then referred at length to the desirability of a State sanitarium for consumptives and a State colony for epileptics.

#### Conclusion.

Legislation is necessary to provide for:

1st. The establishment of a sanitarium for consumptives.

2nd. The establishment of a colony for epileptics.

3rd. The creation of a State Board of Examiners.

4th. A proper amendment to the present State Board of Health Act.

5th. A proper amendment on the line indicated to the City and Village Act.

6th. Dr. Egan recommended as an amendment to Section 14 of the proposed bill for the Regulation of the Practice of Medicine and Establishing a Board of Medical Examiners the following: Providing, that the Board may at its discretion accept as the equivalent of an examination in any part of the subjects required satisfactory evidence of ten or more years of reputable practice of medicine and surgery since graduation, and providing further, that such substitution shall be specified in the certificate hereinafter provided for.

S. R. Catlin, Official Reporter.

The Kankakee County Medical Society held its annual meeting in the Court House, Kankakee, Thursday evening, Nov. 6th.

Dr. Peck presented a paper on **Nasal Tumors**,

The usual business of the Society was transacted, after which followed the discussion and adoption of the **New Constitution and By-Laws, in unison with the State Society**. Arrangements were made to hold meetings quarterly, of which the January one should be a banquet.

..The Society voted to give twenty-four dollars to the State Legislative Committee...

Election of officers resulted in the election of Chas. True, Kankakee, as President; I. L. Lewis, Momence, Vice-President; J. A. Brown, Kankakee, Secretary-Treasurer, the office of Secretary-Treasurer being made permanent.

There are now thirty members in good standing; others will be notified of the adoption of the new Constitution, and it is hoped the membership will be increased.

J. A. Brown, Official Reporter.

The Adams County Medical Society held its regular monthly meeting Nov. 10th, at the Conservatory of Music with the following members present: Drs. Ashton, Baker, Bates, Center, Christie, Jr., Christie, Sr., Fletcher, Gilliland, Grimes, Harrison, Hart, Hatch, Justice, Knapheide, Knapp, Knox, E. B. Montgomery, F. E. Nichols, H. J. Nichols, Nickerson, Rice, Robins, Rosenthal, Sigsbee, Tull, Vasen, Wellenreiter, W. W. Williams, and J. A. Koch.

This was the first meeting under the new constitution and by-laws and after the disposal of the regular business, the consideration of the scientific program was taken up.

Wm. Sigsbee gave a very interesting essay on "Medicine," the acceptance of the term as a remedial agent.

F. E. Tull read a paper on "Visual Hygiene in the Public Schools."

In "American Medicine" not long since, there was an article on Visual Hygiene in the Public Schools, in which it said the time has surely

come when it should be demanded of the State that adequate and scientific hygiene must be provided if school attendance is made compulsory.

This question is one in which I have been greatly interested in the past few years—and especially so when I note the increased amount of eye trouble among our children.

The question is daily asked in the office why it is that so many young people and children have eye trouble and wear glasses, while only a few years ago it was very seldom seen; and these same questioners, who when in school, were probably the ones who had poor grades or were allowed to stop school on account of the symptoms now known to be due to eye strain, are the ones most difficult to convince of the possibility of their child having defective vision.

Formerly, the child who had headaches or any of the very common symptoms of eye strain such as vertigo, nervous irritability, etc., were given lighter work or none at all, and in that way were tided through; but in later years the cause of such symptoms has been more carefully looked into, and today we find the teacher who has a child unable to do the required amount of work accurately—she knowing the average work to be expected of a child whose physical conditions indicate good health—begins to suspect some impairment of vision as the cause, and requests the parent to have the child examined either by the family physician or by an oculist, and in many cases very happy results follow correcting the error of refraction.

The symptoms of eye strain are so many and so well known to all present that it is not necessary to enumerate them; nor is it necessary to go into detail as to the treatment; but the question of greatest importance is why have we had such an increase in eye trouble. And when statistics, in our cities where examinations have been made, show a large per cent of the school children have defective vision, either in one or both eyes, sufficient to need correction by the use of glasses, it is certainly time we were, if possible, locating the cause and making every effort in our power to remove it; or in a few generations the whole nation will be doomed to be slaves to glasses.

One of our prominent men, in speaking of the child's eye, says that the eye of an infant is the same as that of the savage; i. e. adapted for far or distant things, and not for near; and that, however much we may have modified our other organs to suit our modern environments, we have not as yet evolved from a savage far-sighted eye one that can be both safely and comfortably employed all day long in doing near work.

Observations of thousands of school children of ages from four to twenty, both in the country and elsewhere, demonstrate that under the pressure of study the eye balls tend to elongate and increase in size, in direct proportion first, to the number of hours per day they are employed in near work; second, the age at which this work begins; third, to the disabilities (Hyperopia, Astigmatism, ill health, hereditary tendencies, poor light, vicious habits, etc.,) under which their studies are pursued.

Germany furnishes the most fertile field; but from France, Switzerland, and Russia, comes the same story—that the more prolonged the study hour, and closer the work, the more marked, the eye defects when maturity has been reached.

Eminent men from these countries say when we have a few generations of Kinder Garten graduates, and require our children to remain in school and college as long as there, we will have the same conditions in America.

Kinder Garten and primary teachers should be supplied with simple tests, and no child having poor vision should be allowed to receive instruction before nine years of age; and it should be a part of the teacher's duty to note any defect, as they are frequently the only guardians the child has.\*

The Kinder Garten work should require things taught that necessitate the minimum amount of accommodation for near work. Embossing, perforating work, fine sewing, paper lacing, clay moulding and drawing, should especially be avoided.

In our Kinder Garten work, particularly in America, with our stimulating climate, there should be plenty of sunshine and fresh air, which will prove a very great benefit to our children; giving them a good chance to study animal, vegetable, and plant life, which will not only be a benefit, but a pleasure, to them.

I believe that hygiene will yet prevail over the enemy of our natural eye sight, if we can but get the proper legislation.

The discussion was very enthusiastic and was led by H. M. Harrison, followed by E. B. Montgomery, Nickerson and Robbins, and closed by Dr. Tully.

J. D. Justice read a paper on the "**Obliterating lines that have apparently outlived their usefulness in the practice of medicine and surgery of the 20th century.**"

Obliterating lines that have apparently outlived their usefulness in the practice of medicine and surgery of the 20th century.

Quite well do I remember the very general dissension of opinion following the meeting of the New York State Medical Society, which convened its seventy-sixth annual meeting at Albany in 1882, February 7th, 8th, and 9th. A special committee to revise the Code of Ethics, appointed the previous year, consisting of W. C. Wey, C. R. Agnew, W. S. Ely, S. Oakley Vander Poel, and Henry G. Piffard, reported the new code of which the following is the first clause of Article two:

"Rules Governing Consultations.

"Members of the Medical Society of the State of New York and of the Medical Societies in affiliation therewith, may meet in consultation legally qualified practitioners of medicine."

Notwithstanding the aye votes cast by such eminent men as A. Jacobi, Thos. A. Emmett, A. L. Loomis, D. B. St. John Roosa, C. R. Agnew, F. P. Foster, of New York Medical Journal, and G. F. Shrady, of the New York Medical Record, the dissatisfaction was intense against the new code. Medical Journals, during succeeding months, all over the United States, were replete with literature concerning the new code, the greatest majority of them severely criticising



the action of the New York State Medical Society. Some even accused New York specialists of having combined their efforts to further personal interests by arranging a Code of Ethics of sufficient flexibility to permit consultations with such irregulars as would redound to their own profit and still retain an unspotted dignity with the profession at large.

County medical societies over the entire country entered vigorous protests, through delegates, to their respective state societies, adverse to the new code. At the following June meeting of the American Medical Association, C. R. Agnew was turned down in no uncertain terms in his efforts to introduce resolutions supporting the new code. So thoroughly aroused was the profession in the State of New York, for and against the new code proceedings, that a council of the State Medical Association for upholding the national code of ethics undertook a canvass of the State by counties, in 1883.

The new code agitators were not lacking in acumen to keep pace with the movement, as may be noted in June 6th issue of the New York Herald, claiming a list of 1,265 subscribers. The canvass of the council for the national code ending June 21st, resulted in 2,256 affirmative notes, with the number increasing daily. In New York city alone there were about 700 favoring old code, while there were also numbers that were silent. Every effort was put forth to have a complete expression of the regular profession in the State. The exhibit shows 639 in favor of new code; 205 for no code, or rather no code than the new; but, if there be a code, let it be National.

A proof pamphlet of 72 pages issued by the Central Organization of New York State Medical Association for November, 1883, says there are 5,219 physicians in the State, classified as follows:

Committed to the National Code.....	2,424
Committed to the New Code.....	943
Committed to having no code.....	210
Unclassified.....	31
Uncommitted.....	1,611

It further declares that the time has arrived for every member of the profession in the State of New York to declare himself for or against the National Code, and it is earnestly desired that those who are still uncommitted will speedily reach a decision, so that the views of the whole profession of the State may be obtained as to whether it wishes to retain its fraternal relations with the American Medical Association and the regular profession of the United States, or to disfranchise itself therefrom by abolishing the National Code and adopting a New Code of Ethics, not in harmony with it, or by abrogating all codes. You have been sufficiently enlightened in the professional status of that period to refresh memory and indicate the profound earnestness with which both factions acquainted themselves in the matter of a government by Ethics written and unwritten.

Just this sort of interest was required in evolving the advanced step and achievement attained in the successful re-organization of today's American Medical Association. From the agitation of the code revision, during the

years antedating the special committee to revise it, appointed in 1881, to the reading of Article two at the seventy-sixth annual meeting exploding the bomb, that set the greatest thinkers of our land among the medical profession to thinking in unity upon one subject. Never had there been such serious consideration or reflection along lines especially calculated to harmonize in one grand working body, the medical profession of the United States.

The last public exhibition of much note was made during the seventy-eighth annual meeting of the New York State Medical Society, held at Albany February 5, 6, and 8, 1884; when Dr. D. B. St. John Roosa expressed a desire to give an opportunity to abrogate any and all codes by a motion, which was lost by the carrying of a motion to adjourn, being an example of how carefully the lesson on ethics was taught and learned.

While the spirit of American patriotism prevailed in that each votary held to his own sweet conviction, and a modest separation of New York State's New Code adherents obtained, the St. John Roosa idea of the so-much-criticised unwritten Code of Great Britain utterly failed to materialize.

Like every process of evolution involving problems of vital import, and stupendous magnitude, much time was required to reach that state of harmony and working simplicity out of which true advance may result and be maintained. In the matter of Ethics, more than one decade has been necessary to reduce the chaos of a code and by a far-reaching evolution, to place professional Ethics on its present high pedestal. In short, the healing of a schism so suddenly precipitated by the New Coders could not be of primary or secondary intention.

Only the quiet methods of a few unselfish men at the Atlantic City meeting could ameliorate the spirit of discord. Some changes in the American Medical Association methods have been for years a matter thought necessary and conceded by both sides, and the new era came with the Saratoga meeting in June, 1902. The inauguration of the House of Delegates cured the malign influence of bad political methods and established a reform by re-organization. Compact legislation is the life of any great organization, and the House of Delegates is a federation of all the State Associations through which the entire profession of the United States may be as perfectly wielded as a single society.

It would be both entertaining and instructive to detail the many issues required in the process of evolution of this greatest of medical associations, did time permit; but the key note surely lies in what constitutes a legally qualified practitioner of medicine. A correct construction of such is the plank over the chasm and settles the code feature in the matter of affiliation, thus obliterating the hard and fast lines of the Twentieth Century practice. If any will take time to read the decision of Judge Tyson, of the Supreme Court of Alabama, in American Medicine of August 16, 1902, they will be amply rewarded on the meaning of medicine and its practice, the first enactment of which was given in 1823.

Consider for a moment the present fortifica-



tion of our great scientific body, known as the re-organized American Medical Association, in the light of the rapid strides made by the uniting of medical colleges all over the world. Go back with me to 1880.

The American Medical College Association consisted of 69 medical colleges in the United States; 16 of them in the New England and Middle States; 53 in the West and South. Total number of students 8,279, with an average for the first named states of 3,467; for the West and South, 4,812. Nineteen colleges in the West and South had not fifty students, two of them had none, and the nineteen were enough to supply all Great Britain. The price of tuition but \$10 to \$50, accounts for the large number. Reform began in 1881, by raising fees to \$75, resulting in a 50 per cent. decrease in attendance.

The next step was to raise the standard of admission and to then extend time of compulsory college attendance a year, then two, and now to four years; and finally the uniting of combined colleges with their respective State universities. The climax was at last reached by the endowment of a million dollars to Harvard University by John D. Rockefeller. Immediately in the wake of this progressive movement, we observe many of our vast medical journals forming combinations to increase power for the good of the science.

Last, but not least, comes Inter-State Reciprocity in Medical Licensure, the right move at the right time to get abreast of the times. It is with pardonable pride that the Adams County Medical Society, at its last meeting, took a step to the fore front by electing to her ranks other than the so-called regular school, but men who had the courage of their conviction to lay aside the cloak of pecuniary deception and identify themselves with the combined powers to aid by every rational means all suffering humanity, and to take no backward uncertain step in the strife of preventing disease.

R. J. Christie, Jr., read a clinical report of a case of "*Spina Bifida*" of the variety of "myelomeningocele." The case was sent to Dr. Christie's service at the Blessing Hospital, by Sarah Vasen. It was such a severe case that it soon succumbed.

The following applications have been received for membership: Margaret Anderson, H. Rodefeld, W. G. Schmidt, A. H. Schmidt, C. W. Pfeiffer, A. H. Byers, and G. W. Burch of Quincy, and J. H. Leightle of Plainville.

J. A. Koch introduced the following resolution:

Resolved, That the Adams County Medical Society heartily endorses the proposed new Medical Practice Act as adopted by the Illinois State Medical Society at the convention held in this city last May. That our Committee on Public Health and Legislation recommend the new Act to our representatives in the Legislature. That the members individually exert whatever influence they can to secure its passage.

The Society has recently issued a neat pamphlet containing the revised constitution and by-laws, and a fee bill.

John A. Koch, Official Reporter.

The Rock Island Medical Society met on the afternoon of Friday, October 17, 1902, with M. L. Harris, President Illinois State Medical Society, presiding. A conference meeting of the officers of the two county organizations of medical men in Rock Island county was held for the purpose of reconciling their differences, and arriving at some basis upon which the profession could be organized into a unified County Society.

With mutual concessions it was finally agreed at this meeting that both organizations should disband, and that a new county society should be formed, embracing all the members of the former organizations, and such other reputable physicians in the county as should see fit to join in the movement.

Pursuant to this arrangement, a meeting of the physicians of Rock Island County was held in the parlors of the Harper House, Rock Island, Ill., on the evening of October 24. The meeting was called to order by Dr. Carl Bernhardt. On motion, George L. Eyster, of Rock Island, was elected temporary chairman, Emma Morgan, of Rock Island, temporary secretary.

It was moved by E. A. Edlen, of Moline, that the meeting resolve itself into an organization under the name of the Rock Island County Medical Association. The motion was approved.

On motion of Dr. Morgan, of Moline, it was agreed that the officers of the society, until the adoption of constitution and by-laws, should be President, first and second Vice President, Secretary, Treasurer, and Official Reporter. The society then proceeded to the election of officers, which resulted as follows:

President, A. M. Beal, Moline, Ill.

First Vice President, W. R. Freek, Cordova, Ill.

Second Vice President, A. D. West, Moline, Ill.

Secretary, Emma Morgan, Rock Island, Ill.

Treasurer, Louis Ostrom, Rock Island, Ill.

Official Reporter, George L. Eyster, Rock Island, Ill.

On motion, a committee consisting of Jos. DeSilva, George L. Eyster, A. D. West, J. P. Comegys, and F. H. Gardiner, was appointed to draft a constitution and by-laws, to be submitted to a meeting to be held November 7, 1902.

The following list of physicians were made members of the Society, either from their presence at the meeting, or on account of their membership in one or the other of the former societies. There were present at the meeting, forty of this list.

Anderson, Martha, Moline.

Arp, A. H., Moline.

Asay, J. E., Rock Island.

Beal, A. M., Moline.

Beal, A. R., Moline.

Beam, W. O., Moline.

Bendle, J. H., Illinois City.

Bennett, H. S., Moline.

Bernhardt, C., Rock Island.

Block, W. S., Port Byron.

Brand, F. W., Moline.

Browning, H. D., Moline.

Bruner, J. M. O., Port Byron.

Carter, C. C., Rock Island.

Comegys, C. P., Rock Island.

Craig, G. G. Sr., Rock Island.

Craig, G. G., Jr., Rock Island.

Daily, O. S., Moline.  
 DeSilva, Joe, Rock Island.  
 Dunn, L. O., Moline.  
 Eckhard, Peter, Taylor Ridge.  
 Eddy, W. S., Milan.  
 Edlen, E. A., Moline.  
 Eyster, George L., Rock Island.  
 First, F. H., Rock Island.  
 Foster, C. T., Rock Island.  
 Freek, W. R., Cordova.  
 Gardiner, F. H., Moline.  
 Hall, B. F., Rock Island.  
 Hall, S. B., Rock Island.  
 Hollowbush, J. R., Rock Island.  
 Huntington, W. K., Moline.  
 Kerns, S. E., Moline.  
 Kohler, A. E., Moline.  
 Lamping, T. J., Moline.  
 Long, J. H., East Moline.  
 Looker, F. W., Moline.  
 Ludewig, W. H., Rock Island.  
 Marquis, B. V., Buffalo Prairie.  
 Martin, W. B., Sherrard.  
 Miller, A. J., Edington.  
 Montgomery, A. B., Reynolds.  
 Morgan, Emma, Rock Island.  
 Morgan, J. W., Moline.  
 Meyer, R. C. J., Moline.  
 Myers, J. F., Rock Island.  
 Myers, W. F., Coal Valley.  
 Ostrom, Louis, Rock Island.  
 Rankin, J. E., Watertown.  
 Rice, J. F., Hillsdale.  
 Sala, E. M., Rock Island.  
 Sargent, E. B., Moline.  
 Soule, Earl A., Moline.  
 Swenson, J. G., Moline.  
 Trembly, J. J., Moline.  
 Wadsworth, Paul., Rural.  
 West, A. D., Moline.  
 Wiggins, G. A., Milan.  
 Whiteside, C. E., Moline.  
 Wright, Emily, Moline.  
 Wyland, J. M., Moline.

An adjourned meeting was held at the Harper House, Rock Island, Ill., on Friday evening, November 7.

The committee to prepare a constitution and by-laws reported, with slight modifications, the constitution and by-laws for County Medical Societies recommended by the committee of the American Medical Association. The constitution and by-laws were adopted by the Society. The name adopted under this report, was that of The Rock Island County Medical Society.

The President and Secretary were instructed to submit the constitution and by-laws to the Judicial Council of the Illinois State Medical Society, and apply for a charter to be issued to The Rock Island County Medical Society, as an affiliated body of the State Society.

The President and Secretary were instructed to prepare a program of scientific work for the next meeting, and arrange for a banquet to be participated in by the members at that time.

Under the article of the by-laws providing for the appointment of a Committee on Public Health and Legislation, the President appointed as such committee, Drs. C. C. Carter, E. M. Sala, and L. D. Dunn.

The Society then adjourned to meet at the

Harper House, Rock Island, Ill., on Tuesday evening, December 9, 1902.

George L. Eyster, Official Reporter.

The Marshall County Medical Society met in regular session at the Library building in Lacon, on Tuesday, October 14th, at 1:30 P. M.

The meeting was called to order by the President, E. S. Everett.

The members present were E. S. Everett, L. G. Thompson, Robert Boal, S. O. Hendrick, B. A. Martin, E. W. Oliver, W. G. DuFour, W. H. Jones. Visitors: Drs. Royce of Sparland, Potts and Twedale of Lacon, Hill of Lawn Ridge and Barbour of Magnolia. Minutes of the last meeting read and approved.

The following applications were favorably reported upon by the Board of Censors and the applicants unanimously elected to membership in the Society. J. A. Swem, Henry; F. B. Ireland, Varna; Wm. Patch, Whitefield.

The first paper read was by S. O. Hendrick, the subject being, *the relation of the medical fraternity and the laity to each other*. This was a very interesting paper and was thoroughly discussed first by B. A. Martin and then by other members. E. S. Everett then took up the subject of *infant feeding* and covered the subject fully in all its phases. He discouraged the use of all so-called prepared infant foods and said that none of them compared favorably with a properly modified cow's milk, when the child for any reason could not be nursed by the mother. He then gave a number of formulæ for the modification of milk suitable to different ages of the child.

The discussion of this paper was heartily entered into by all present.

E. W. Oliver of Wenona, who was next on the program gave an interesting account of the recent epidemic of smallpox, especially citing his experience with it in his home town.

This was followed by a discussion of the diagnosis of this disease in the form in which it has been so prevalent in the State.

W. H. Jones then read a paper by J. A. Swem of Henry on *Typhoid fever*. The author of the paper dwelt particularly upon the treatment of the disease and gave an account of a number of cases in his private practice and the result of his treatment of same.

Most of the members entered into the discussion of the subject and all the different modes of treatment were interestingly brought out.

This closed the program for the day and officers were elected for the ensuing year as follows: President, E. S. Everett, Lacon; Vice-President, C. W. Shepard, LaRose; Secretary, W. G. DuFour, Speer; Board of Censors, S. O. Hendrick, Henry; B. A. Martin, Lacon; W. H. Jones, Henry.

The president appointed a committee of arrangements for next meeting as follows: W. G. DuFour, Speer; W. H. Jones, Henry; C. W. Shepard, LaRose.

The Society unanimously endorsed the "Proposed bill for the regulation of the practice of medicine and establishing a board of medical examiners in the State of Illinois."

On motion meeting adjourned to meet in Lacon, Tuesday, May 12, 1903.

W. G. DuFour, Official Reporter.



The Chicago Medical Society met November 5, 1902, the President, Wm. A. Evans, in the chair. Henry Banga reported a case of **Ruptured Tubal Pregnancy**, and exhibited the specimen. The patient was twenty-four years old, and nursing a nine-months' old baby. Vaginal examination disclosed the uterus in a normal position. From the absence of a tumor by vaginal examination, he concluded that the patient was still bleeding. The fact that the woman was ill for thirty-nine hours, and that there was no tumor, hematocele or hematoma, made him believe that the blood oozed out into the free abdominal cavity, and he therefore advised immediate operation. A laparotomy was performed at once. The patient made an excellent recovery. As the result of his experience, he said it could be laid down as a practical guide that if one made a diagnosis of internal hemorrhage and examined the patient and failed to find a hematoma or hematocele, he could be reasonably sure that hemorrhage was still going on. *Per contra*, if, a few hours after the attack, or repeated examinations after the onset, one found a gradually increasing tumor which became harder, he could be almost certain that the hemorrhage would stop of its own accord.

**X-Ray Tube Shields and Specula for Treating Cancer of the Rectum and Other Cavities.**—J. R. Pennington, in a paper on this subject, said that in treating cancer of the rectum with the X-ray he had encountered many difficulties. Growths in this region are very securely and completely surrounded and protected by heavy bones and thick healthy tissues. His first efforts were directed toward passing the rays through the healthy structures.

As soon as Caldwell's tube was put upon the market, he added it to his list. In this tube the anode or target from which the X-rays issue is placed at the distal end of the tubular prolongation. This projection may be introduced into the rectum or vagina through any of the ordinary rectal or vaginal specula, and the rays applied to the diseased rectum, prostate gland, vagina, uterus, larynx, etc. It can also be inserted through an artificial opening in the abdominal wall, and the rays applied to malignant growths of the viscera, upper part of the rectum or sigmoid. In treating cancer of the rectum, however, he has found it very difficult and unsatisfactory to manipulate the tube through a speculum. To obviate these difficulties, Caldwell has also devised an elaborate handle and shield, with which to manipulate the tube and limit the area exposed. Because of the imperfections and objections to the Caldwell handle, the speaker had discarded it and had made a larger hole in his shield, and attached a spring to its distal end to facilitate connection with the anode or target, and constructed an animal tissue cot, which is drawn well up and over the metallic shield. This provides a small space between the tube and the tissues treated. To secure the best results, the tissues treated should be as near as possible to the tube, and not be in direct contact with it. If the tissues make direct contact with the tube, then the energy will be transmitted by conduction and not by induction, and the inductive action is the vital principle. This covering also keeps the tube dry and protects it from the filthy secretions and

discharges, and as a means of safety to the patient should the tube collapse from puncture or other accidental cause. As the cot is constructed of thin animal tissue, it does not interfere with the X-light radiations.

Notwithstanding the practicability of this tube, because the source of energy is so close to the tissues treated, his results with it in treating cancer of the rectum have not been satisfactory. As the X-radiance from the normal X-ray tube is more powerful than that from Caldwell's tube, and as the energy will have more therapeutic value when properly directed, the essayist had, for the purpose of using the ordinary tube in localizing and directing the X-radiance in the rectum and other cavities, constructed for him a tube shield and specula, which he exhibited.

He demonstrated that the energy from an ordinary tube is more powerful at a distance of six or eight inches from the tissues treated than from Caldwell's tube when it is in almost direct contact with them.

**Notes on Diverticula of the Male Bladder.**—L. E. Schmidt read a paper on this subject. There is still some confusion in the nomenclature. It is necessary to distinguish between false and true diverticula. A false diverticulum is a closed cavity communicating with the bladder, whose walls are not formed by any parts of the bladder wall; for instance, an abscess cavity which perforates into the bladder or the hollow space of a tumor which communicates with the bladder through exulceration. True diverticula are sacculations of the bladder wall proper. They are congenital or acquired. The congenital ones show all the constituents of the bladder in their walls, while acquired diverticula, if they become larger, as a rule, have a wall which is made up of mucosa and submucosa only. If a diverticulum originates in a part of the bladder which is covered by serosa, peritoneum may be found as a third layer. Very shallow recesses in the bladder wall, which do not represent separate cavities, may be called, according to English, "bladder cells." Acquired true diverticula are the consequence of "work" hypertrophy and trabeculation of the bladder. One of these, trabecular encircled areas, gives way under the increased pressure and becomes more and more stretched and dilated until it breaks through the muscular coat and protrudes, hernia-like, into the abdominal cavity. The shape of the entrance of a diverticulum is first rhomboidal, later on more rounded. The body of the diverticulum, originally of the same diameter as its entrance, becomes more and more enlarged, so that it acquires the so-called bottle-shape.

Solutions injected into the bladder for treatment may occasionally be partially retained in a diverticulum and reappear at intervals after micturition is finished. The chronic retention and stagnation of urine in a diverticulum will lead to cystitis or to the precipitation of solids, so that indigenous stones may be found. A kidney stone caught in a diverticulum grows rapidly to a bladder calculus by the apposition of urinary salts from the stagnating, concentrated contents of the sacculation. Diverticula may easily become attached to inguinal or femoral hernias, thus complicating the symptoms and the eventual operation. If a diverticulum becomes



attached to a pericystitic exudate, sharp pain at this particular point will be felt at the beginning of each micturition, the contracting bladder causing the diverticulum to pull at the pericystitic focus.

The indication for choosing operation for stone in diverticulum depends upon the possibility of dislodging the calculus. A dislodged concrement can be crushed, otherwise cystotomy has to be resorted to.

The diagnosis of a diverticulum can be made with certainty only by the aid of the cystoscope. Some authors recommend a total resection of those diverticula, which give rise to serious symptoms.

**Operative Dysmenorrhea.**—G. Kolischer read a paper on this subject. Under the term dysmenorrhea are, as a rule, included all conditions which cause extreme discomfort and pain immediately before and during menstruation. The term dysmenorrhea, in a strict sense, should be reserved only for those menstrual troubles which are due to certain nervous, nutritive, or mechanical changes in the uterus proper, and which are characterized by one leading symptom, the spasmodic painful contractions of the uterine body.

Nervous and nutritive dysmenorrheas, the latter either due to a general anaemia, or to hyperplasia of the uterus, yield readily to appropriate treatment. Nervines and hydro-therapy in the first group, Thure Brandt's massage, resistance gymnastics, bicycle riding in the second group. Apostoli's electric treatment, although frequently successful, has decided disadvantages. It is not free from the dangers of subsequent infection and inflammation, and causes in virginal patients the laceration or extreme dilation of the hymen.

Mechanical dysmenorrhea is based either on an abnormal tightness of the internal os, or the general narrowing of the cervical canal. In the latter cases the cervical tissue is, as a rule, very rigid. By these conditions the flow is partially retained in the uterine cavity, thus giving rise to painful contractions. Or the general narrowing of the cervical canal does not give space enough for the mucosa swollen by the menstrual congestion, so that the stretching of the cervix adds to the discomfort.

Anteflexion, so generally ascribed as a cause of mechanical dysmenorrhea has nothing to do with this condition. Mechanical dysmenorrhea is observed equally frequent in straight or retroflected uteri, while even extreme anteflexion, provided the cervix and its mucosa are normal, does not cause dysmenorrhea.

The diagnosis of mechanical obstruction is made by sounding, and occasionally by inspecting the cervix during the early stages of menstruation. In some cases the swollen mucosa protrudes from the external os. Dilation of the cervix and incision of the junction between cervix and body have, if any at all, a temporary effect only. It is necessary to resort to plastic operation in order to secure certain and permanent relief. The operations devised by Defontaine, Snegiereff, Alexanderoff and others do not seem to answer this demand.

The author employs a method which consists in splitting upon the cervix by bi-lateral incisions and excision of a wedge-shaped piece of

tissue out of either side. In case of necessity, this excision can be carried through around the whole circumference of the cervical canal. The incision wounds are afterwards closed by sutures. In 47 cases collected in the last seven years the result was in all but one case absolutely perfect, and up to date no relapse has been observed. The last mentioned case became in some way or other infected, so that inflammatory and edematous conditions of the concerned parts still prevail, thus causing, up to this time, absolute failure, so far as relief of the dysmenorrhea is concerned. In three of the operated cases pregnancy and smooth confinement followed the operation after two, five and six years' respectively, of matrimonial sterility. The author restricts the operation to selected cases of mechanical dysmenorrhea after all the other bloodless methods have been tried and failed. The hymen should only be destroyed by the surgeon after the patient has been fully made to understand the importance of this step.

J. Clarence Webster said that among the varieties of dysmenorrhea met with it is admitted that in the last ten or fifteen years much less prominence has been given to the subject of mechanical dysmenorrhea than formerly. Years ago stenosis of the os externum or the os internum, or of the whole canal, was put down as a cause of dysmenorrhea. The older text-books were filled with descriptions of operations for dilating and dividing the cervix to relieve dysmenorrhea. Those who have had experience in many cases know how unsatisfactory the operative treatment has been in a great many of these supposed mechanical obstruction cases. Careful investigations had led to a change of opinion. It has been pointed out by investigators that the condition of the cervical canal, in the intermenstrual period, is not to be taken as a criterion of the condition present during menstruation.

He thought more prominence should be given to membranous dysmenorrhea. He does not mean the ordinary classical text-book picture of dysmenorrhea, according to which there is a complete cast of the uterine body shed; but he includes under the term membranous dysmenorrhea a much larger class of cases. He has had under observation for one year a girl, seventeen years of age, who passed at each successive menstrual period shreds of hard mucosa; in another case the whole mucosa; in other cases portions as small as a ten-cent piece. He had observed a number of cases in a similar manner, and he has found that not infrequently there is a condition in which the abnormal portion of the uterine mucosa is shed, not the microscopic outpouring of a few cells which normally takes place, but actual shedding of the superficial epithelium, with some of the subjacent connective tissue.

A. Goldspohn said that the most rational treatment, and that which has given the best results in cases of dysmenorrhea of the type under discussion, has not been cutting of any kind, particularly in the so-called obstructive cases, unless it be a slight incision to widen the external os and to overcome the former retention of cervical mucus, which tends to produce the cervical pouch. But rather than make incisions, he would dilate the uterus carefully, taking plenty

of time to do so, dilating the cervical canal in the lower part of the uterine cavity, the internal os particularly, with wedge-shaped dilators, with divulsors applied in various directions, but, above all things, never using excessive force sufficient to cause rupture, but bearing in mind that the muscular tissue requires gentle, persistent force to make it elongate. In other words, do not tear the tissue, but stretch and make the stenosed cervical canal wide enough possibly to insert the little finger, and do the necessary curettement, then pack the uterus solidly, particularly the cervical canal, so that the dilated cervix will be held as wide open as possible.

G. Kolischer, in closing the discussion, said a large majority of cases of dysmenorrhea could be cured by simple means, and this point he desired to impress upon the general practitioner. The more simple cases can be very much benefited or cured by Thure Brandt's method of treating dysmenorrhea.

With reference to dilation of the cervix, he maintained that there are certain cases in which he did not succeed with dilation. Even with extreme dilation the cervix was very apt to return to its old condition. Forcible packing of the cervical canal or uterus was liable to cause infection, and practitioners frequently see the sequelae of such infection.

**Massage and Gymnastics in Gynecology.**—The author of this paper, George Rubin, pointed out the indications and contraindications of gynecological massage and gymnastics. He said this form of massage was indicated, first, as a means of diagnosis, and, second, as a means of treatment. In the first, massage alone is necessary, but in the second massage and gymnastics or gymnastics alone ought to be employed. Massage should not be administered in acute inflammatory conditions, for in such cases rest is essential; but in subacute or chronic inflammations it often produces astonishingly good results. Massage is contraindicated in carcinoma, sarcoma, tuberculosis, abscess, and cysts of the genital organs. In most instances where massage is contraindicated and radical treatment is refused, gymnastics alone will be beneficial as a palliative by diverting the circulation from the affected parts and by tending to improve the general system. Among the disorders where gynecological kinesitherapy does the most good are displacements of the uterus. It stimulates the muscle fibers of the stretched ligaments to contraction and improves the nutrition of the entire suspensory apparatus of the uterus. It works well in flexions, which are usually due to atony of the uterine musculature, by improving the circulation and toning up the muscle fibers.

**Technique.**—The technique in gynecological kinesitherapy is very simple. No specially devised instruments or apparatus are necessary. All one needs is a bench, a stool and two hands. The bench ought to be about five or six feet long, sixteen inches high, and about twenty-four inches wide. It is better to have it slightly padded, and with a head rest. The stool ought to be of the same height as the bench. The massage is usually preceded and followed by certain gymnastic movements. The movements to begin with are flexion and extension of the arms. The patient sits on the corner of the

bench, head upright, spine in full extension, and chest thrown forward. The knees are widely separated. The arms are up and forward, and the hands of the patient are held by the operator, palm to palm, his fingers around the patient's wrist and vice versa. The operator stands on the stool, one foot forward and facing the patient; the patient is now directed to flex her forearms on her arms, and to carry her elbows outward as much as possible. Flexion and extension ought to be performed with slight resistance, in the former by the operator, and in the latter by the patient. These movements are repeated four or five times. The flexion coincides with expiration and extension with inspiration. These movements and abduction of the thighs are the most important in gynecological kinesitherapy, on account of their decongesting effect on the pelvic organs. It should be omitted in the first two or three days of menstruation, except in menorrhagia, in which condition it is highly beneficial.

**Massage.**—This is executed bimanually, one or two fingers being in the vagina (the French masseurs use the index fingers alone, while the Germans introduce two fingers), the pulp of the finger, or fingers, is lightly pressed against the cervix, as near to the isthmus as possible. In displacements or flexion of the uterus it is well for the operator to try and correct the position first and steady it in that position by the left hand. Where there are no adhesions, this is easily accomplished, and in the other cases it ought to be brought as near the normal position as possible. The right hand is placed on the abdomen, and after obtaining a complete relaxation of the abdominal wall, the massage is commenced and may be performed by circular friction, stroking or vibrations. Pressure should be avoided. The affected organs should not be massaged directly, but around them.

Direct massage is indicated in subinvolution or in flaccidity of the uterine musculature itself. In nearly all other conditions the indirect massage should be given. This treatment should last from two to four minutes only, and should be done with a very delicate touch. The position of the patient should be the same as for an abdominal exploration, with the thighs flexed and separated, so as to permit a maximum amount of relaxation of the abdominal wall. The pelvis should be somewhat raised, which is easily accomplished by having the patient place her fists under the seat. The operator is seated on the stool to the left of the patient, leaning forward and resting his left elbow on his left knee, thus giving him more freedom to manipulate the cervix with his finger. The last part of this treatment, and not the least, is the abduction of the thighs, which is performed in the following manner: The patient's head and shoulders are supported by a pillow, or otherwise, the legs flexed at a right angle, the abdomen, pelvis and thorax are raised so that it will form a straight line when looking from the knees down to the shoulders. The patient is then told to spread apart her legs while the operator resists slightly; then they are brought together by the operator while the patient resists.

This form of gymnastics has a decided influence on the muscles forming the floor of the perineum. These movements may be repeated



about ten times, if the patient is not debilitated.

The essayist spoke of the objections to the Thure Brandt method, saying that one of the principal drawbacks of it is its slowness in obtaining results. It often takes many weeks or months to benefit or cure a patient by this method, and it is therefore unpopular with the poorer classes.

The author reported twelve cases in which he had resorted to the methods detailed, and although the results are far from being remarkable, the cases demonstrate along with reports of others the usefulness of the Brandt method in a certain class of gynecological cases. He believes that if the Brandt method is executed by the physician himself, or by one who has been especially trained for it, but always under the eye of the physician, then the value of this method in certain cases can hardly be disputed.

John Kercher said that he had obtained very good results from massage in cases of adhesions, where there was no inflammation or infection. He detailed the case of a patient upon whom a curettement and laparotomy had been performed, without very much relief, but by means of massage, which extended over a course of two years, the patient was apparently cured. He cited several other cases in which he had obtained beneficial results.

As to massage in cases of chronic constipation, it is an impossibility to effect a cure in a short time. Many of these patients were inclined to be enthusiastic at first, but if they do not see results after a dozen or more treatments they are apt to become discouraged, and quit. It is very essential that patients should place themselves under this treatment for a considerable period of time, in order to secure good results.

A. Goldspohn said that the enthusiasm for pelvic massage that existed about six years ago or more has rather waned. Medical literature contains hardly anything now on this subject; nevertheless, while pelvic massage cannot effect the amount of good that general massage does in other parts of the body, it is one of the efficient, non-surgical means in gynecology, and those men who think gynecology consists only of cutting or in giving doses of medicine were very much mistaken. Massage, carefully selected in proper cases, administered by a skilled bimanual examiner, certainly no one but a physician, is an efficient agent along with other things, such as hydrotherapy, exercise, etc.

**Report of the Committee on Medical Defense.**—The Committee on Defense made the following report:

1. That they believe that assistance in defending damage suits, and probably aid in other legal matters, is desired by the membership of the Society.

2. The experiences of the British Society, the New York County Association, and of the New York State Medical Association, and the Philadelphia Medical Society, together with information from various sources that they have been able to gather together, leads them to believe that a feasible plan of aid for defending damage suits can be devised for the Chicago Medical Society.

3. They would recommend to the Society

(a) that a fund for this purpose be established, and that \$1.00 of each member's annual due be placed in this fund; (b) that a committee of five, known as the Medico-Legal Committee, be elected by the Society; (c) that this be one of the Standing Committees of the Society; (d) that the Committee on the Revision of the Constitution be requested to take note of this action in arranging the new Constitution; (e) that this committee be empowered to employ an attorney or attorneys on such a basis, and to do such legal work for the Society as seems desirable; (f) that nothing in this resolution, or in any act of this committee, shall or can bind the Society to contract expense in excess of a sum represented by \$1.00 from each annual due paid; (g) that they give notice of a motion providing for the setting apart of such funds; (h) that the Society should recommend to the Medico-Legal Committee that an attorney be employed to care for suits against members up to the time of going into court, without any expense to the members, but that for the court expense of members the Society is not to be held liable, provided that they also recommend to the committee that some arrangement be made with the lawyers for the defense in court of the members of this Society, said expense to be borne by the member or members involved; (i) they recommend that this committee, in this work, co-operate with the present Medico-Legal Society and affiliated societies of the Chicago Medical Society; (j) that the above recommendations to the standing Medico-Legal Committee are advisory, and are not mandatory.

The Chicago Medical Society held its meeting Nov. 19, 1902. President Wm. A. Evans, in the chair.

**Case of ventro-fixation, pregnancy, inversion of the uterus, death and post-mortem.**

Wm. E. Holland and Byron Robinson presented jointly a case of ventro-fixation followed in two years by pregnancy, which proceeded to full term. There was a short normal labor, and normal delivery. Death occurred three and a half hours post-partum. A post-mortem examination revealed complete inversion of the uterus. The uterine circulation was injected *in situ* with red lead, the uterus removed, and an X-Ray of the specimen secured. The authors presented observations and deductions concerning the relation of ventro-fixation to inversion of the uterus.

Charles E. Paddock propounded the question, Why is it we find so many of inversion of the uterus now, when there were so few formerly? He believes it is due largely to a misunderstanding of the Crede method of the treatment of the third stage of labor.

Rudolph W. Holmes said that some years ago he presented a paper on the "Etiology of Inversion of the Uterus." He collected at that time 830 cases, 75 per cent. of them being due to spontaneous causes; 25 per cent. were due to the Crede method, and to traction on the cord. He thinks abdominal pressure is the direct cause of the inversion in the larger proportion of cases.

A. McDermid said it was he who performed the operation of ventro-fixation upon this



patient some three years and a half ago. In listening to the report, he thought it was believed atrophy had occurred, owing to the method of fixation adopted, and that the atrophic band had inverted the uterus. When the uterus is fixed by any method to the abdominal wall, the anterior wall of the uterus during gestation, not being allowed to expand, becomes thick and dense, while the posterior wall becomes attenuated, and he thinks it is rare that the posterior aspect of the fundus is so attenuated that it is liable to cause inversion. The speaker had used the modification method of fixation of Martin, of this city.

C. S. Bacon said it is hardly fair to attribute the inversion to the ventro-fixation, and gave his reasons for so thinking.

Franklin H. Martin described a method of ventro-fixation which he had used in 173 cases. Of this number, only 30 were women who could bear children, and of these 30, 2 had children within one year to two years, after the fixation had been made. These women went on to term, were confined in a normal manner, and made no complaint. In each of these cases he had examined the uterus afterwards, and found it suspended.

C. W. Barrett thinks that ventro-suspension or fixation should be reserved for those cases in whom pregnancy may not occur afterwards. He believes the weight of clinical evidence is tending that way.

#### The Gravity of Bronchitis in Elderly Men and the Safety Valve Action of Relative Tricuspid Insufficiency.

Robert H. Babcock read a paper on this subject, in which he reported a case. The case illustrates the gravity of bronchitis in elderly men, and teaches some instructive lessons from which he thinks the following conclusions may be drawn:

1. Bronchitis in elderly, although robust, men may readily become chronic. Presuming on their previously good health and vigor, they think they can easily throw off their cold, and hence are apt to ignore medical aid until after the bronchitis has become settled and obstinate.

2. The cardio-vascular degenerations so often present and unrecognized in elderly men increase the tendency of bronchitis to become chronic. This is because the stiffened arteries and chronic myocarditis, even though the heart remains potentially equal to the demands of everyday life, tends to the production of pulmonary and bronchial congestion, which, when bronchitis once sets in, renders it less amenable to ordinary treatment. Moreover, the physician who may, perchance, be consulted is apt to overlook the influence of cardio-vascular changes, and contents himself with prescribing expectorants, whereas he should at the same time lessen the congestion by a brisk calomel cathartic. He should also in many cases inhibit exercise and attention to business, that the heart may be relieved of unnecessary strain.

3. Another element of danger in the bronchitis of elderly men is pneumonia. In most cases the bronchitis predisposes to a pneumonia, which may develop after the lapse of weeks or months, as in the case narrated.

There is, however, the possibility that the bronchitis, which sets in abruptly and severely, may be but an attendant or manifestation of pneumococcus infection, and may obscure the signs of pneumonia when this is lobular.

4. A fourth danger lies in the effect of the bronchitis upon the heart. Chronic myocarditis develops so insidiously that one may not always be able to detect it, and cannot foresee how little extra strain may be required to seriously impair its potential strength.

Even should pneumonia not ensue, the mechanical strain of the bronchitis, especially if it leads to atelectasis and emphysema, and of repeated violent attacks of coughing, is capable of seriously damaging the degenerated right ventricle, the dilatation of which aggravates the already existing congestion.

5. Should such dilatation lead to relative tricuspid insufficiency, this is not to be regarded as a sign of danger *per se*, since it is in reality a safety valve which for a time protects the ventricle from disastrous overdistention. The tricuspid regurgitation is a criterion of the degree of mechanical strain to which the ventricle is subjected.

6. Such safety valve action not only furnishes a brief respite to the patient from the death threatening him, but affords to the physician a little longer interval in which to battle for victory, while it, at the same time, indicates the necessity of relieving dangerous congestion by cathartics, possibly also venesection, and cardiac tonics.

**Circular Insanity.** Richard Dewey reported a case of circular insanity which he had studied clinically, differentially and medicolegally. In this case there were five successive cycles of manic-depressive psychosis, which occurred with considerable regularity. The later phases were more regular, and mental deterioration was gradual. He spoke of a remarkable succession of legal contests which were conducted by the patient himself, the patient subsequently dying of typhoid fever.

Thor. Rothstein presented a report covering the examination of the brain, both gross and microscopic. He also exhibited drawings and photographs. Examination of the brain showed structurally a normal state. The findings were not characteristic of any organic or degenerative change in the brain.

Daniel R. Brower said he was more or less familiar with this case from the first clear evidence of the patient's insanity in 1889 up to within a few months prior to his death from typhoid fever. He agreed with the essayists that the case was one of circular insanity.

Harold N. Moyer said the case was unique. He believes that this individual and his mental defects constitute one of the most interesting clinical observations in insanity that has ever occurred in this region, if not in the country. He concurred in the diagnosis.

Sanger Brown regarded it as an exceptionally clear case of circular insanity. He called attention to one point, namely, that in textbooks it is said that these patients lose flesh during the exciting interval, but this case contradicted such a statement, in that the patient would

gain from one hundred to one hundred and twenty-five pounds during the period of excitement.

It was likewise stated in textbooks that these patients do not have delusions. There were marked delusions in this case.

L. F. Barker confirmed the report of Dr. Rothstein in every way. As to the actual pathogenesis of such a psychosis, no one knew. He thinks we shall have to await chemical studies before any light is thrown upon the pathology of this psychosis.

**Ankylostoma Duodenale.**—Joseph A. Capps reported a case of ankylostoma duodenale. This disease rare for this part of the world occurred in a resident of Iowa who had been a laborer in Central America. He had frequently eaten without washing the soil from his hands and had thus become infected with the parasite. Severe anemia and eosinophilia led to the suspicion of a parasite and examination of the feces established the diagnosis.

He gave the life-history of the parasite, described the modes of infection, and demonstrated specimens illustrating different phases of development, and then discussed the diagnosis and treatment.

The following new members have been admitted. Addresses are always in Chicago unless otherwise stated.

Alcorn, A. J., 1145 Tripp ave.  
 Anthony, Frank, Sterling.  
 Baker, F. R., 2601 N. Paulina st.  
 Bates, F. H., Elmhurst.  
 Beyerlein, L. J., 1105 Lincoln ave.  
 Blomgren, C. E., 1450 Belmont ave.  
 Carver, S. C., 101 Laflin st.  
 Dodge, H. E., Franklin Park.  
 Costello, Charles A., 4304 Grand blvd.  
 Dohrmann, George, 781 W. Wrightwood ave.  
 Duckett, W. F., Madison, Ashland and Ogden ave.  
 Fay, M. J., 306 Reliance bldg.  
 Flanagan, B. F., 734 W. 43d st.  
 Friduss, S. L., 4804 Ashland ave.  
 Getz, Michael, 92 State st.  
 Griffin, M. A., 1986 N. Clark st.  
 Grosvenor, W. F., 1156 Sheridan road.  
 Guest, Thomas A., La Grange.  
 Hager, S. Mead, 100 State st.  
 Handke, Otto K., 133 Madison st.  
 Harmison, Frank B., 3300 State st.  
 Hepburn, A. H., 1223 W. 63d st.  
 Higgins, Arthur E., 35 5th ave.  
 Langer, Carl, 812 E. 70th st.  
 Loewy, Arthur, 100 State st.  
 Lofer, J. W., Oak Park.  
 Lofton, F. A., Glen Ellyn.  
 Mackey, A. N., 1127 Sheffield ave.  
 Malone, G. B., 175 Dearborn ave.  
 Menn, Rudolph, 15 Lincoln ave.  
 Montgomery, W. A. D., 305 N. State st.  
 Pence, C. D., 859 Turner ave.  
 Pigall, Joseph S., 987 Ogden ave.  
 Potter, W. E., 623 Forest ave.  
 Reichmann, Max, 804-92 State st.  
 Reilly, Joseph, 4328 Union ave.  
 Schultze, Moritz, 1723 N. Ashland ave.  
 Swan, V. U., 100 S. Fifth ave., Maywood.  
 Tischart, P. J., 70 State st.  
 Vanderhoof, H. W., Wheaton.

White, Mary B., 1406-103 State st.  
 Windell, U. G., 309 Park ave.  
 Wynekoop, C. I., 1748 N. Halsted st.

The Chicago Neurological Society held a regular meeting October 23, 1902, with D. R. Brower in the chair.

#### Myasthenia Gravis.

Dr. Moyer presented a patient, twenty-three years of age, whose early history was negative, except an undetermined infection of exanthematous type. The patient spoke of having had two attacks of measles about three years ago, but was not very ill. The attacks were near the time when his first trouble with the eyes developed. At that time glasses were fitted for diplopia. Dr. Pusey fitted the patient with his first glasses, and he would give the eye findings. Dr. Pusey said the patient was first seen by him November 6, 1899, when he complained of double vision. His vision in the left eye was 6-9, in the right eye 6-6; with minus one sphere with half a cylinder, his vision was 6-5 in the left eye, and 6-5 in the right eye. At that time he had esophoria of 22 degrees, with right hyperphoria. The esophoria later became exophoria. On the 8th of December, one month later, he worked all day until midnight, with no blurring of vision, no diplopia at the time. His esophoria had disappeared, but he had slight hyperphoria. On January 4, 1900, he had esophoria of one degree, some hyperphoria. July 3, 1900, he saw him again, when he complained of double vision. He had exophoria of eleven degrees, with positive divergence of the eyes. August 6 he was refracted again carefully with a mydriatic. The refraction had changed 3-4 D., he having become more myopic with 1-2 D. cylinder at different axes. He then had an exophoria of eleven degrees. He disappeared on the 6th of July, 1902, and was not seen again until the 26th of September, when he complained of double vision all the time, with inability to converge the eyes. Vision at this distance was doubled. He noticed paralysis of the internal recti muscles. The eye muscles moved in every direction except the internal recti on both sides. There was no limitation of motion in any direction except the paralysis of convergence, also paralysis of motion on either side on the part of the internal recti muscles. Six weeks ago there was limitation of motion of the muscles in every direction except one of the external recti.

Dr. Moyer saw the patient September 8, at which time there was a marked general weakness; patient complained of stiffness of the lower extremities, feeling as though his knees were bound, as the patient expressed it. There was some pain for a time, but this gradually disappeared. It was not very marked. On two or three occasions, since September 8, patient has had marked ptosis, more marked in the left eye than in the right. It would last for two or three hours at a time, then for a couple of days. It has never been in both eyes at the same time. Until the middle of September there has been progressive loss of strength, which has continued to the present. There has been no marked increase in weakness in the last two or three weeks, but it has remained about as it was. The eye-grounds are normal. Aside from the ex-



treme muscular weakness there are no objective signs. There is no swaying with the eyes closed. Patient's knee jerks are not marked, but they are to be elicited readily. The superficial jerks are all present. The pupils react to light. At the present time there are no disturbances in pain sense; his sense of feeling is normal. It is simply a pure muscular weakness, without appreciable muscular atrophy. There is no disturbance in his general health. His digestion is normal; his bowel movements are normal; his appetite is good; he sleeps well, but the muscular weakness is very pronounced; he has numbness in the index finger; the right hand is a little stronger than the left; the facial muscles are weak. A difficulty of which patient complains is a weakness of his jaw muscles; when he eats, his muscles get tired.

Dr. Goodkind asked whether there was any disturbance of speech, to which Dr. Moyer replied that the voice seemed peculiar, but the patient said it was unchanged.

**Cerebral Syphilis, dementia with nuclear degeneration of some cranial nerves and atrophy of one-half of the Tongue.**

Dr. Moyer presented a patient, thirty-seven years of age. Four years ago (August, 1898), the patient went to Dr. Ingals for paralysis of the vocal cords. At that time he was very hoarse. He learned from Dr. Ingals that there was complete paralysis of one vocal cord, while the other moved. Patient was given strychnia and local treatment, shortly after which the paralysis disappeared. A year later the paralysis returned. This was two years ago. Then patient was well until the summer of 1901, at which time he did not feel as well as he had previously. There was nothing marked in his history until the autumn of that year, and at that time he had what his wife described as "a spell." Sitting at the table, he tipped over some glasses, staggered, and could not find his way about. At this time he was working very hard at his occupation of machinist. He improved until November, after which he became very tired and wanted to lie down most of the time. He slept a great deal. He ceased working last November. About that time he began to see double, the diplopia being vertical. In February of this year his right eye turned outwards. At this time the diplopia was lateral. He then developed pain over the right eye, which later shifted to the top of his head. He then consulted an advertising eye specialist, who "pulled" the eye straight and treated him for one month. Pain then shifted to the back of the head. He resumed his work again during the spring, but did not remain at it very long. He could not work effectively; he could not keep his mind on what he was doing; he made mistakes. He finally had to give up. In June he went to the country, when his throat became worse again. He had some paralysis of the vocal cord, with hoarseness, which disappeared. A few weeks ago his mind began to wander, and it was noted that his memory was impaired. He had difficulty in swallowing, and at night has been wetting the bed. At the time Dr. Moyer first saw him, patient had a typical Argyll-Robertson pupil on the right side. The light reaction was present in the left eye, but

was sluggish. Accommodation of distance was normal in both eyes. There was complete paralysis of the right external rectus. The eye grounds were normal. The movements of the tongue were defective and tremulous. There is a history, although it is somewhat indefinite, of specific infection dating back to ten or eleven years. Some of the symptoms have disappeared under specific treatment. Patient has well-marked atrophy of the left side of his tongue. Under liberal doses of the iodides great improvement in the symptoms followed, particularly of the eyes. His memory is better; also his speech. Dr. Brower asked as to the condition of the reflexes, to which Dr. Moyer replied that they were exaggerated, more so now than when he saw him last. Dr. Brower asked whether there was any distinct ankle clonus, to which Dr. Moyer replied there was not.

There were two features of striking interest in this case, the nuclear degeneration and dementia. The patient has had no emotional exaltation or mental depression. His mind has been weak and feeble; he could not remember where he put things; he could not go to a neighboring store for an errand without forgetting it before he got there. The association of nuclear degeneration with dementia he had not seen before. The atrophy of the tongue was organic. The reason he presented it in connection with the other case was because of the somewhat striking similarity in the eye conditions of the two patients, yet their etiology and pathology were very different. There is little doubt as to the specific history in this case, according to the statements of the physician who treated the patient. He thought the diagnosis to some extent has been cleared up by the marked improvement, both in the physical symptoms and mental state, under specific treatment.

At first, when he saw the patient, and noticed the atrophy of the tongue, and paresis of the eye muscles, he thought he had to deal with a case of myasthenia gravis.

In regard to the treatment he had taken iodide of potash in very large doses.

Dr. Patrick said he had treated only two cases of myasthenia gravis, and in them strychnia had accomplished more than anything else. He did not think either of his cases was typical. The patient was given one-sixteenth of a grain of strychnia, three times a day, for a year and a half. The patient had almost ceased taking it now.

Dr. Moyer asked Dr. Patrick whether he regarded his (Moyer's) case as typical one of myasthenia gravis, to which Dr. Patrick said yes, and he thought it would be well for Dr. Moyer to continue to give strychnia month after month.

**Tabes, General Paralysis and Charcot's Joint.**

S. J. Walker presented a man who came to the Polyclinic October 13. He was forty-four years of age, married fourteen years, and has three living children. The first child his wife had was born dead at term. The other three are living and well, aged respectively eleven, twelve and thirteen. The mother has never had a miscarriage. The patient's occupation was that of a buyer of dry goods. He gives a clear history



of specific infection a little over fifteen years ago. Otherwise he gives no history of any serious illness. He complained of no trouble until ten years ago, when he said he had rheumatism in the legs. Upon close questioning him, these pains proved to be of a lancinating character. These pains have continued since, off and on. Seven years ago he had an ulcer at the base of his right big toe, which proved very intractable to treatment, and consequently this toe was amputated. Three years ago he began to notice that he could not walk so well in the dark. For the last three or four years he has had difficulty in urinating, a relative incontinence. He has had no eye symptoms of any kind, not even transitory diplopia. No ptosis. This completes the history up to about seven months ago, when he fell and sprained his right ankle. At the time he said there was a great deal of pain in it, with swelling. The swelling extended as high as the knee. The pain continued, off and on, for five or six weeks, and then gradually subsided. Since then he has had no pain whatever in the joint, but the swelling of the ankle joint is still present and in degree about what it was a few weeks after the injury. An X-ray picture was taken by Dr. Hazelton, at the Polyclinic, but the man shook so much that the Doctor did not succeed in getting a good skiagraph, so that the negative was valueless. The enlargement of the foot is not due to bony formation, in the opinion of Dr. Hazelton. He thought it was cartilaginous enlargement. The patient had been working at his trade up to the time of the injury, six or seven weeks after the injury, when he returned to work, he noticed impairment of his memory. He had considerable figuring to do on articles of apparel, and was discharged at the end of five or six weeks because of the mistakes he made in his work. Upon examination, the Argyll-Robertson pupil is found. He has no knee jerks. He has analgesia of the legs, and patches of anesthesia upon the trunk. He has slight analgesia extending over this patch of anesthesia on the right side behind. The anesthesia was marked in the patches that are shown on the chart. He has the characteristic stumbling speech. He has shown considerable dementia. In short, the mental condition is plainly that of general paresis. The patient is exhibited on account of the rather unusual combination of diseases and the Charcot's joint.

The diagnosis is made of Tabes, with perforating ulcer of the foot and Charcot's joint of the right ankle, and finally general paresis supervening in the tolatie affection.

#### Lead Palsy.

Dr. Walker also presented a man, who presented himself at the clinic on October 13. He is thirty-three years of age, and works in a planing mill. He has five children, all of whom are well and healthy. His wife has never had a miscarriage. The family history is fairly good. The patient has never been exposed to metallic poisoning, so far as he knows, nor to arsenic, nor has he been subjected to any drug intoxication. Three years ago he was at the Alexian Brothers' Hospital for three weeks, and was thought to have consumption. A careful examination at the present time does not re-

veal any lesion in the lungs. He has never had any infectious disease, and has never been seriously sick. He considered himself perfectly well until about fifteen weeks ago, when he noticed swelling in his wrists and in his ankles, with some pain. The pain passed out of the ankles almost immediately, and after two days in bed he was able to walk around. About the second day he noticed weakness in his wrists and hands, and at the end of three or four days he suddenly lost power in his wrists. In other words, he had double wrist-drop. Since then his condition has been about the same; no paresthesia; no subjective symptoms of any kind except wrist-drop. Upon examination, Dr. Walker finds that patient has double wrist-drop with the supinator involved on the right, but not on the left side. Paralysis of the extensors is more marked upon the right than the left side. Patient is right handed. There is partial reaction of degeneration in all the extensor muscles, and supinator on the right side, this being more marked on that side than on the left. There is no objective sensory disturbance. His knee jerks are equal and normal. The one pupil responds to light and to accommodation (the other eye is artificial). Patient looks cachectic, and an examination of the blood shows 75 per cent hemoglobin, reds 3568600, whites 2100.

Dr. Walker spoke of one thing which may be a very valuable indicator in cases of lead poisoning, and that is the presence in the red cells in nearly every case of lead poisoning, if the case is at all severe, of little granulations. These are found in every field in any severe case of lead poisoning. From a medico-legal standpoint, Grawitz, of Berlin, who does much good work on blood, regards these small granulations of great value, because when once present they do not disappear until the lead is out of the system. Dr. Walker examined this patient's blood for these granulations in the red cells, and was unable to find them. He examined five or six specimens, each one of which was negative. This man is not addicted excessively to either alcohol or tobacco. At most, he drinks four or five glasses of beer daily, and usually not that much. Patient was closely questioned as to exposure to metallic poisoning, and Dr. Walker had not been able to elicit any cause for the neuritis. It corresponded in distribution to lead palsy, except that the supinator on the right side is involved. The patient has a questionable lead line. The condition of the gums is so bad, almost scorbutic, that it is difficult to say positively that there is a lead line. He has never had lead colic, although that is usually the rule preceding lead palsy.

Dr. Brower said that some people were sensitive to lead poisoning at certain times. He mentioned how it was possible for one to have lead poisoning in Chicago. In this city, in certain parts, the water pressure at certain hours of the day was so low that the water did not reach the upper parts of houses; the pipes are empty of water for hours at a time, then the water is turned on, the pipes are coated with the oxide of lead, which is washed off, and people were poisoned with lead in this way. He asked about the water supply of the factory in

which the patient worked, to which Dr. Patrick replied that the man does not come in contact with paint, bisulphide of carbon, gas—nothing but wood.

Dr. Moyer suggested the possibility of poisoning by food.

Dr. Patrick said the patient has never had lead colic, and lead palsy, without preceding lead colic, in cases of chronic lead poisoning, is unusual.

Asked in regard to the treatment, Dr. Walker stated that it consists of hot baths, the use of iodide of potassium, and massage.

Dr. Brower said a case came under his observation a few years ago of a middle-aged man, who had wrist-drop. He could not ascertain the source of the lead poisoning until the patient had been under treatment for some time, then he found that he was having his hair dyed.

Dr. Goodkind asked whether the patient had any optic atrophy.

Dr. Walker replied that he had not.

The Physicians' Club of Chicago held their regular monthly meeting and dinner at the Sherman House on the evening of October 27, 1902, Arthur R. Edwards presided, and the topic for discussion was **Fees and Collections**. Papers were read by Isaac A. Abt, Mr. C. F. Meyer, of C. F. Meyer & Co., collectors, Frank T. Andrews and William S. Cameron, Esq.

#### **FEES AND COLLECTIONS, IN RELATION TO GENERAL PRACTICE.**

By Isaac A. Abt.

This very important topic, which has been assigned for discussion this evening merits our most careful consideration.

I think that our worthy Secretary has honored me excessively in selecting me to respond to this toast. My acquaintanceship with this subject is more of a theoretical than of a practical nature; perhaps he has overestimated me as a fee collector. It goes without saying that I shall have nothing brilliant or startling to say to you. I shall speak of commonplaces.

I am to speak for the general practitioner; in other words, for the rank and file or the high privates of the profession in contradistinction to those who occupy the commanding positions—the specialists.

Many of us are general practitioners, who deal in a specialty as a side line, some are pure specialists in one department, and forsooth some are specialists in all branches, and some are general practitioners.

The general practitioner is the man who treats the entire family. He confines the mother, takes care of the baby, treats the father, and sometimes is asked to prescribe for the servant or the coachman, or he is asked to take a friendly interest in the canary bird or pet dog or cat in case of illness.

To speak seriously, the man in general practice has no sinecure, if he is young or just beginning, he worries and pines his life away, so that he may enter the fray. When he is established and has, so to speak, a practice, his troubles but commence. He is supposed to be on duty and watch at every moment to answer every beck and call, to be always pleasing,

always gallant, and never unruffled. He should know all, foresee all, and do all. It is true that in many instances he becomes the friend of the family. Their griefs, their pains, their woes and their sins are unfolded to him, and become his burden.

A man gives up much to his patients. He who puts his soul in his work gives up his energy, his pleasure and his pastime. It is needless to say to you gentlemen that it is wearing on mind and body.

Nowadays, with the telephone not only on every street corner but in homes everywhere, it is impossible almost to be away from the patient for a moment.

Shall the general practitioner continue, or shall he be replaced entirely by specialists? There can be no doubt that the well-informed general practitioner cannot and ought not be replaced. In the families, where he practices, his services, his interest and his friendship are of inestimable value.

For those patients who have been faithful to us for a long time, who repose confidence in us, and whose friendship is prized—for these no sacrifice is too great, no labor too arduous. In these families, where one feels secure of his standing, a man retains his self-respect; his orders are implicitly obeyed. Any reasonable request, whether it be for counsel or nurse, is never questioned.

In those families where one feels himself a stranger, one might hesitate to ask for counsel, lest it unduly alarm or weaken his standing with the family.

For all the labor and responsibilities of the general practitioner, what is his recompense? Is it sufficient? where is the fault? Patients are very exacting with us; they make great demands. It is true they are entitled to all we can give them. The medical attendant in return is entitled to a fair recompense. In these days of prosperity, when all the commodities of life are expensive and decent living costs money, the family physician must have the wherewithal to support his family.

The remuneration is inadequate, it is small in proportion to the services rendered.

The medical men themselves are often to blame. Many fear to ask for respectable fees. I know men who scorn the idea of asking for money from the patient; the idea is repugnant to them. Others would ask for a more commensurate fee for services, but fear that by so doing they may lose patronage.

All people cannot pay the same fees. The man whose income in \$12 per week is generally subjected to a great hardship when he has to pay \$14 per week for medical attendance, excluding the price of drugs, and perhaps nursing.

There is a class of patients who are earning good salaries, or who are engaged in paying business enterprises. Some of this class can and do pay their medical attendant.

A certain number of this class, however, expend all they earn in luxurious living, and have very little or nothing. They do not lay aside for the so-called rainy day, and when sickness does occur, a new and unexpected expense is encountered, and consequently the



payment for medical attendance is neglected altogether or is very slow.

If another case of illness should soon occur in this same family, another physician is called and he in turn becomes the victim.

These people, if they do not already know, pretty soon find out that it is easy to contract a debt for medical services, and payment for the same often may be made or not, at the discretion of the patient.

There is another class of patients who are affluent, but who object to moderate charges, who want reductions from their bills at the end of a period of illness. If their so-called claim is not allowed, they threaten to withdraw their future patronage.

The upshot of the whole matter is that the doctors, like no other class, allow themselves to be fooled. There is always some doctor in the community who is ready to underbid or undersell the other. I have already said that all patients cannot pay alike. There should be and always has been a sliding scale of prices. The rich can and ought to pay more than the poor.

But it is a mistake for medical men to offer their services at bargain prices. There are enough patients to go around, and everyone could well afford to see a few less every day, if they were paid decent fees. The scale of prices I alluded to should be flexible enough to meet all conditions already alluded to. Every doctor has a free list composed of many who are well able to pay. This is unfair. It is unfair to everybody—the doctor, his colleagues and the patient himself. The general practitioner ought not to acquire the reputation for extortion. Most general practitioners are spoken of in some quarters as being good to the poor. The charity work should be limited as far as possible to hospital and dispensary work. The majority of patients do not appreciate cheap or free medical attendance. Their gratitude is soon forgotten. The Germans like to say that "Undank ist der Welt Lohn." Gratitude or ingratitude, though, we would prefer the former, and most often receive the latter. Gratitude is mere sentiment. We ourselves rejoice when we are successful. But we must value our own services. Others value them accordingly as we value them ourselves. The tailor never made a fine fitting suit for your wife or yourself and then gave you 20 per cent discount for your gratitude. So long as money is the medium of exchange and we need this medium so that we may occupy respectable places so that the world may adjudge us successful, so that we may provide for our families, and finally that we may be decently disposed of after we are dead, it is only just that we should receive sufficient remuneration for our labors. Our patients should be asked for fees which are sufficient.

Referring to the subject of collections, there are experts among us to-night who will tell us all about this intricate subject. From our standpoint the subject might be disposed of and simplified if we slightly changed our methods of doing business. It should be largely a question of credit. We are told every day, and there must be some reason for saying so, that doctors are, as a rule, poor business men; that they are

poor bookkeepers. The busy general practitioner, who has a hospital and a general practice to look after, who likes to glance at the newspapers, read his medical journals, read up his cases, and occasionally glance under the covers of a new book, would be a very excellent business man or bookkeeper if he had the time. As I started to say, we are too liberal in extending credit, or at other times, as the business men say, we give too long dating. Credit should only be extended to responsible people, and all bills should be paid in ten to thirty days (at the maximum). The butcher, the blacksmith, to say nothing of the merchant prince, could all teach us lessons. Before extending a line of credit to us the aforesaid individuals ask us who we are, and where we come from, and whom we can refer to. If the answers are not satisfactory, the goods must be paid for in cash. What doctor before extending credit finds out whether the individual asking for same is entitled to it? If he did it would be much better for him. Practitioners ought to do larger cash transactions. If we did there would be less collecting, and we would have more money.

I desire to be very brief concerning the collection of accounts. We must have collectors. They are a necessary evil. They are our friends, and frequently do very well for us. We should be careful of the kind of a collector that we have to deal with. We may be judged by the company we keep. Ordinarily I am opposed to law suits by general practitioners for collection of fees.

1st. They engender an intense animosity.

2nd. They are expensive.

3rd. Lastly, as they are usually conducted, the suits are usually brought before an impossible judge, in an impossible place, at an impossible time. It is an unjust, mean business, and reflects on all who are parties in the suit.

In this county every man is entitled to a fair and impartial trial. The method is unfair, undignified and unworthy of decent men. We ought to discourage it. If a suit for recovery of fees is to be brought, it should be done fairly, honestly, and in the spirit of good law and decent citizenship.

By Mr. C. F. Meyer.

I beg to express my appreciation of the courteous invitation extended by your Secretary to address you upon the subject for discussion this evening. I shall not attempt to indulge in any oratory or tell you any funny stories, but shall simply endeavor to tell you in a plain, homely way my ideas and conclusions as to the manner in which a physician should collect his accounts, keep his books, etc., and shall also make a few general suggestions, which I think will at least prove of interest, whether your ideas agree with mine or not.

As most of you may know, I have been identified with the physicians' collecting business here in Chicago for the last fifteen years, and do not want you to consider anything that I may say here to-night to be in the nature of advertising my own business, but it may be necessary for me to refer to certain personal experiences that I have had; but I do so simply for the purpose of illustrating my ideas.

That all the profession are more and more



each year drifting towards commercialism seems to me beyond doubt; and yet there is about the medical profession a certain personality that never can be eliminated. Nevertheless, the physician of to-day, if he desires to keep abreast of the times, must run his practice substantially upon a commercial and business-like basis.

Dealing with this subject upon a commercial basis, the first thing is to keep your books properly. Physicians, as a class in Chicago, I can confidently assert, are extremely poor business men, have very little knowledge of book-keeping, and either cannot or will not take the time to attend to them properly. For illustration: If you go to a grocer and buy a pound of butter, he charges you with a pound of butter, 30c, not merchandise, 30c. If you buy a spool of thread you will be charged with a spool of thread, and so on through the entire list, and the charge is made immediately upon the purchase of the goods. Upon the first of the month, or each week, if you so arrange, you receive from the house that extended to you credit a statement of the amount you owe them properly itemized. Compare the books of a commercial house with the books of a physician, and you will find that the physician's book will, in nine cases out of ten, simply have a stroke or a cipher or something of that sort after a certain date and after the name of a patient, and in most cases simply the last name of the patient, and quite often simply the street without the number. What that stroke means is known to the doctor, and nobody else. It may mean that a baby was born on that day, or that a man had his leg amputated, or that it was simply a call for some ordinary sickness.

My point is this: The physician should, immediately after he makes his visit, office call or operation, put down in his book of original entry (commonly called a day book) the full name of the person who is to be charged with the account, the street number and address, if possible, the occupation and business address, the name of the person treated, the disease he was treated for, or just what services were rendered; and then make a charge at the same time for the work done. The reason for wanting these particulars, is that in case the debtor moves he can be traced through the city directory, if his full name is given and his last residence address and his occupation. Generally a man always keeps his same business when he gives his name to the directory man. He might have been a bookkeeper, but may change his occupation to that of a teamster, and when giving his name to the directory man still stick to that of a bookkeeper; this makes it easy to locate him.

I have in mind a physician for whom my firm is collecting, and for whom we collect hundreds of dollars every month, whose practice is very largely among the Swedish people. He has three offices in different parts of the city. There are Andersons, Olsons and Swansons until you cannot rest, but this doctor will always give the first name of Olson. He will tell you whether it is Andrew, Swan or Nels. He will tell you his street number, and whether he lives in the third floor rear or the first floor front. He will tell you whether he is a landlord, a barber, a carpenter or a preacher. We have for this very physician, by checking up the new city di-

rectory with the old city directories two or three years back, traced hundreds of people and collected from them hundreds of dollars that otherwise would have been lost. Without being personal, and without knowing that any one of the physicians referred to is here to-night, I could cite you an experience of another physician who puts a memorandum on his cuff, or an another who may make a note on the back of an envelope, lose the paper, forget just what the entry is and put it down on his ledger according to his best memory, being perfectly honest in his belief, but very often mistaken. Remember that your ledger entry does not go into court, unless you will swear that it is the original entry.

This is the kind of a physician that will give you a bill against Mr. Johnson for \$25.00. If you say to him, "Doctor, where is this Johnson, or what does he do?" he will say, "That is for you to find out; he lives in Chicago. I saw him on State street last Christmas." I, only to-day had a letter from a South Side doctor who owed my firm \$8.00 commissions. He said: "You have a bill against Hill for \$13.00 which you dropped, can't locate; why don't you make him pay? I met him on an Indiana avenue car last week." My records showed that I had five doctor bills against him, we had lost track of him, but had located him by getting a new doctor bill against him when all of the other accounts had been dropped. They were again opened up. This was done, and can only be done by a system which my firm has, and can explain if you desire.

It has happened in my own experience hundreds of times where a doctor sends a bill for collection to us, say for instance, Mamie Jones: Medical services, \$10.00. When our collector presents the account at the residence of the Jones family and asks for Mamie, the parent gets mad and asks the collector what business he has asking for Mamie, she being a little girl ten years old; when, upon investigation, we find that the claim is for medical services rendered to Mamie, of ——— street, and that she is the daughter of Thomas Jones, and that the physician opened an account with Mamie instead of the parents, who are liable. In cases of this kind the physician should always open up the account with the person who has got to pay it. If Mamie Jones is treated, the account should be opened up with Thomas Jones, the father. If the mother is a widow, it should be opened up under her name, and a note should be made upon the books for services to Mamie.

When we ask a physician, of the kind last referred to, for an itemized bill, supposing his original bill to be \$25.00, we are just as likely to receive an itemized bill for \$8.00 or for \$39.00 as to get one for the right amount. This generally results in the patient getting mad, refusing to pay a dollar, the doctor having no books to stand on to bring into court, and probably the loss of a bill, or a very cheap settlement.

I know of many other instances that where we have a bill to collect, say for \$15.00, that the debtor would say: "Get me an itemized bill, and I will pay you \$15.00 if it is right, or I will give you \$5.00 to settle," that the doctor very frequently says: "Meyer, take the \$5.00," and then when we inform the debtor that we will

take the \$5.00, he says: "That shows that the doctor cannot give an itemized bill, and I won't pay anything." This is a case where if the doctor had given an itemized bill, he could have gotten every cent the debtor owed, providing he could have explained his bill, but he could not do so on account of poor bookkeeping.

Do not run your account for a month, or two months, or six months, and then go back and make a charge for work that was done weeks or months previously. Make your charge at the time the services were rendered.

There are printed books that are very commonly used by the ordinary practitioner with which you are all familiar, and if properly kept are ordinarily all right—such as O. C. for Office Consultation, a stroke for a call, or a cipher for a call or something of that nature—but where special services are rendered and a special charge is made a note of it should always be made in the physicians's book.

In books of the kind above referred to, OP for operation is not sufficient. I believe, however, that the better way for the physician to do is to immediately, after making his visit, office call or performs his operation, put down in his book of original entry in full what services were rendered, and no strokes should be put down. The most severe test of bookkeeping as to its sufficiency in court matters is the Probate Court. If it will go there it will go anywhere, as in the Probate Court books prove the account.

The five essentials of any item are: 1st. The date. 2nd. The full name and address. 3rd. The nature of the services performed. 4th. The amount charged for such services. 5th. To whom the services were rendered. If the books are kept in this form it matters not how vigorously the claim is contested. You can always produce evidence that the charges are reasonable; whereas, if you put down "operation" \$50.00, you are not permitted to say what the operation was, and as the books do not tell the court has no means of knowing whether the charge is reasonable or not.

Where the service is anything but a visit or on office call, there should be either in the space allotted or carried to the bottom of the page as a reference, a statement of exactly what the services are and the circumstances, such as time, with entry into the amount charged; that is, if it is an operation: Amputation of arm, two hours.

The great objection to these ready-made or mechanical books is that proper spaces are not provided for the physician to make a note of the special charges, and it seems to me that if a physician should be inclined to adopt any of the suggestions referred to in the way of special charges, that it would be just as easy for him to write out the word visit or office consultation as to use a stroke or a cipher, and thus his books would speak for themselves without having to refer to any table of explanation.

Do not render a bill to a patient for \$50.00 and then send one to the poor devil of a collector for \$100.00. Under ordinary circumstances he has to take enough abuse without this. Where a bill is rendered for the full services for a specific amount it is very questionable if you can ever collect any more. When you once render a bill for a certain amount stick to it, and do not

try to change it afterwards, and always make your bills conform to your books. If you desire to reduce your bill, render your bill for the full amount; then make a note upon it to the patient that if the bill is adjusted with you within a certain time you will allow a discount of a certain amount, that otherwise you will not, and make a note of this memorandum to your patient upon your books.

"It is the early bird that catches the worm," and the physician who keeps track of his patients and sees that his account is presented to them at such intervals as he thinks it should be, is the one who will get his money. It seems to be the general rule among patients that the doctor is to be paid last of all, and the only way I can account for this is that the debtor does not send his bill to the patient promptly enough. If he treats a man in June for two or three weeks, the doctor thinks the man is in hard luck, and perhaps does not mail him a statement until the first of November. When his sickness has been forgotten the doctor's kindness has been forgotten, and he says to himself: "I will pay the doctor when I have got everyone else paid."

Upon the question of presenting bills, I fully realize that a physician may have a great number of patients to whom he will send a bill only once in six months, or possibly only once a year, but for the general run of his patients he should mail a bill on the first of every month, or else the first of the month following the date that he has ceased to render services. If no word is received after one monthly bill has been mailed let it run ordinarily during that month, and upon the first of next month mail another statement. If the claim is not paid during that month you might use appropriate rubber stamps calling debtor's attention to the fact that the account is over due upon the next bill that is mailed, if you still desire to give further time, but it seems to me that after you have finished your services and have given a man sixty days' time, and have received no response to your bills, that it is only justice to yourself that you should have a collector call. Of course, there are many cases when you should not wait sixty days; for instance, boarders or strangers, or for services rendered under peculiar circumstances. I do not mean by this that the account should be placed with a collector as a bad account. It is a very easy matter to have your collector call upon the patient in a polite, gentlemanly manner, and solely as your private collector, just the same as a collector from Marshall Field & Co., or any other business house would call upon you if you let your account there run for over thirty days. If, after the collector has called, representing himself solely as your private collector, and has not been able to obtain any results or any satisfaction, and no reason is given why the account should not be paid that you regard as satisfactory, the claim should be put through the regular channels for collection with a written demand after that, possibly, and then suit, if advisable. I know from actual experience of a great many cases where such bills have been placed with my firm for collection and handled in the way above suggested that the physician is not in any way prejudiced by collecting his bills in that way, and that the patient will more



quickly return to him if the bill is paid than he would if it was still unsettled; and I could cite a great number of instances where I have had during the course of one year five or six bills against the same patient, some of them very wealthy, that have been collected only after a personal call was made by my man, who represented himself as being the doctor's private collector.

Strange as it may seem, I still have some faith in human nature. Not very much, but still I have some left. I know there are many cases where people are honest and desire to pay, and for the present time cannot pay. These people should be kept track of in a way so that when their condition is bettered the account can be politely called to their attention and a settlement obtained in installments.

There are, however, very many cases where the physician is most shamefully imposed upon, where the people can pay but will not pay unless literally forced to; people that live better than the physician, that can give theater parties, receptions, and live in style generally. These are the people that are the hardest to deal with. The laboring man who is making on an average of \$1.50 a day is the man who pays his doctor. The man who lives upon the Boulevard is the one who wants the doctor at his beck and call every minute, and expects the laboring man at \$1.50 a day to pay his bill.

I believe that when a physician permits an account to run over three months, without taking steps to have it collected other than his own efforts, he makes a very great mistake. The first feeling of the patient towards the physician is one of gratitude; then is the time to pay his bill. If it runs for a few months he will become indifferent, then defiant, and lastly absolutely abusive. He knows that there are about five thousands physicians in Chicago, that 90 per cent of them are easy marks, and that if he owes Dr. A he can very readily send for Dr. B, and after that for Dr. C, and so on down through the alphabet. I could cite a great number of cases where my office has had from ten to fifteen, or even twenty, bills against the same debtor.

When an account is turned over to your collector you should make a memorandum of it upon your ledger account, and it seems to me advisable to have some code with your collector to use in marking your bills, so that your collector can know how you want them handled. For instance, the system we have adopted is as follows:

A. Handle very gently as my private collector.

B. Use your judgment as to how to collect.

C. Get the money any way you can.

D. Sue at once and charge the costs to my account.

One reason we adopted this system was that it was a very frequent occurrence for a physician to send in a bill against a man and write across the face of it: "Sue this dirty pup immediately," or possibly the physician might use a little stronger language. I have known of cases where that was done. The bill was first presented to the man before suit, he would ask to see it, and the collector would naturally hand him the bill. You can imagine what the man

would say when he saw the doctor's memorandum to us. A very bad case of hydrophobia would be extremely mild compared to the debtor's conduct towards the collector.

When patients call upon you and make arrangements to settle you should notify your collector at once. It is very unpleasant, both for the collector and for you, where a patient comes to your office and you make arrangements for settlement, and you do not notify the collector. This is another case where the collector is abused.

When a request is made for an itemized bill or any question concerning the collection of an account is referred to the physician the sooner it is answered the better. The best thing to do is to "strike while the iron is hot," and while the debtor may offer a certain amount to-day, if he does not hear that the doctor has accepted that proposition until three months after he made his offer, the chances are the money is all spent, and if he has to wait sixty or ninety days for an itemized bill the same excuse is given why it is not paid then.

You might be a little interested to know something about the difficulties that a collector has to meet. It is nothing unusual for the collector to have the door slammed in his face, to have water thrown on him, or to have a chair pitched over the banisters at him. The physician is abused to the collector and the patient in turn abuses the collector to the physician. If we should stop to consider for one minute the various stories that we hear about physicians, questions of blackmailing, claims that the doctor killed the child, wife or husband, or that the doctor was drunk when he called, that he should have his license to practice revoked, that the doctor did not know enough to take care of a sick cat, and all such foolish, nonsensical questions, a collector would not be in business for three months if he took any stock in these stories.

Another trouble in the collection of accounts is that the physician sometimes hesitates to tell a patient what his charges will be. He will pass the matter off with a smile and say: "Oh! we will arrange that; that will be all right," or some such statement. The man will say: "Well, I only have \$5.00 with me." And the doctor will say: "That's all right; give me the \$5.00." The doctor will then send the collector a bill for \$5.00, \$10.00 or \$15.00 more, and the debtor will then say he has made a full settlement with the doctor. It seems to me that when a man asks what the charge for the service will be he should be told. Just as a doctor would be told if he ordered a suit of clothes. In fact, he should be told what the charges will be whether he asks or not, so that there can be no question after you have finished rendering your services as to what you were to charge. This course, strictly pursued, would save many misunderstandings.

Just remember that the collector's life is not a bed of roses; that he has his troubles and difficulties; and if he is a good and honest collector he will be diligent, persistent and a good, hard worker; that he is always looking out for the doctor's own interest. Whenever it is necessary he takes the doctor's part, and incidentally stands a good deal of abuse that the doctor knows nothing whatever about.



Don't expect too much of your collector. He is not infallible, and he cannot bring every dead beat to time.

I trust that the few remarks I have made this evening will be accepted in the same spirit in which they have been offered. You may agree with some of my ideas, or you may not agree with any of them, but the suggestions I have made have come from fifteen years of hard work and worry in the business of handling collections for physicians of Chicago.

The legal questions involved I have not touched upon, but will leave that phase of the topic to Mr. Cameron, my partner.

By Frank T. Andrews.

The surgical treatment of the fee question requires considerable skill, much more than I possess, so I come rather in the spirit of inquiry than with any hope of aiding in solving the various riddles presented. Of course, we have the printed **fee bills** of the various Medical Societies to guide us in determining the size of the fee for operative cases. When I read that for amputating a finger I may charge from \$10 to \$300, and that for removing an ovarian cyst I am entitled to collect from \$50 to \$5,000 I feel satisfied with the decision, and can sit back in my chair content with the knowledge that the question is settled so easily. Of course there is a slight difference between \$50 and \$5,000, and the exact figure must not be arrived at by taking into consideration various modifying conditions. First:—

Has the patient \$5,000?

If not, can she borrow it?

If so, will she?

If not, what can she do?

And if that is the best she can do, should I not be generous and let her off at that, at the same time conferring upon her the degree of G. P?

The ability of patients to pay is a self-limited disease and may run a long or a short course, with frequent relapses. The willingness to pay is essentially a disease of the poor. Only this morning a decrepit Irish woman blessed me and said she would gladly pay me a **million dollars** if she had it. I thanked her and charged her a million on the books, just to make my year's work average up. I made her a deduction, however, of \$999,998, so that now she only owes me \$2.

Practically the willingness and ability of patients to pay will govern our scale of charges. The willingness is largely a matter of education. Anyone who has been in the habit of paying \$5 a visit will never again be satisfied with a \$2 doctor. Then the appearance of prosperity adds to this willingness. I had occasion to go by **street car** to a consultation on Emerald avenue. "How much is it?" she said. "Ten dollars," says I. "Go where," she said, "I can get a **buggy** doctor for that." The next time I went in an **auto** and charged her double, much to her joy, for she was a great lady on Emerald avenue that day.

But, now a word to those who have become **great**. In the long run, **reputation** is the basis of all charges, and I hold that it is the duty of each and all to live up to his reputation, and to charge accordingly. Put on the tariff. Protect

the young men by letting them have a few small fees. And let us all work together to down the **leech** who asks a commission, the **vampire** who wants to divide the fee, and the **thief** who collects the fee for the visiting operator and turns over the small end.

By William S. Cameron, Esq.

The subject this evening is so comprehensive and embraces such a multitude of sins, from a lawyer's standpoint, that I am somewhat at a loss just where to begin or where to end. I have assumed, however, that as a general proposition you are not posted upon questions of law which may be of interest to you, and shall, therefore, endeavor to give you a few general ideas upon questions that continually have to be met in the collection of physicians' accounts when legal proceedings are instituted.

A great many debtors seem to have an idea that a physician cannot collect his account by law until one year has elapsed after the services were rendered. What possible reason there ever was for such a belief I have never been able to discover, but there is no foundation for it, and the physician is legally entitled to institute suit the moment he has ceased to render his services.

Another peculiar idea is that so long as a debtor is making payments, no matter how small, he cannot be sued; as, however, the debt is due when the services are completed the physician is entitled to the full amount at once, and may sue if he chooses, even though the debtor is willing to pay in installments.

A great many physicians, and physicians of good standing, have an idea that the fee bill adopted by the Chicago Medical Society, or some other medical society, fixes what the court or jury will decide to be a proper charge. If they would stop to think for just a moment they must know that a body of men cannot get together and establish certain charges to be reasonable, and thus make law. A physician or surgeon is entitled, however, to a reasonable fee for his services; that is the only limitation; what is a reasonable fee is a question for the court or jury to determine, and in arriving at what is a reasonable fee it is proper to take into consideration the age, experience, ability, and standing of the physician; the locality where the debtor resides, and to a certain extent the financial condition of the debtor. If there is any contest as to the reasonableness of the fee it must ordinarily be proven or disproved by physicians. There have been extremely few cases that my office has handled where one physician has gone upon the stand and sworn that, all the circumstances taken into consideration, the bill of the attending physician was too large.

Where the question as to what is a reasonable fee for ordinary services is submitted to the court or jury I have found the limit to be from about \$3.00 to \$5.00 in a first-class locality and from \$1.00 upwards in a poor neighborhood, and \$2.00 to \$3.00 a visit in what might be termed the ordinary neighborhood. This, of course, is only for ordinary calls, and special services or consultations are paid for at a higher rate.

It has been held in this State that a stranger summoning a physician to render services to a third person is not liable, but that the person

who accepts the services and to whom the services are rendered is liable. If, however, a third person summons a physician and says that he will pay the bill, to charge it to him or words to that effect, he is liable. If it is simply in the form of a verbal guarantee, such for instance as, "Doctor, if A does not pay you, I will," the person giving the verbal guarantee cannot be held: for the law is that in order to hold one person for the debt of another that debt must be guaranteed in writing.

The exemptions afforded a debtor in this State are quite liberal, consisting of a homestead estate to the amount of \$1,000.00 and personal property to the amount of \$400.00, where the debtor is the head of the family. Where the debtor is not the head of the family he has no homestead exemption, and is only entitled to \$100.00 worth of property, but in order to claim his personal exemptions the debtor must, within ten days after the demand is made upon him by the constable holding the execution, file either with the Justice before whom the judgment is obtained or with the officer holding the writ, a schedule of his entire personal property holdings. If any personal property is omitted from the schedule it is not exempt and may be levied upon. If the schedule is not signed or properly made out it may be disregarded by the constable.

A judgment bears interest at the rate of 5 per cent per annum, and an execution may be issued upon the judgment every seventy days. It is then necessary for the debtor to schedule upon every execution within ten days after a demand is made upon him, and while he may do this once or twice, or even half a dozen times, if the matter is persistently followed up, the time will come when he can be caught napping and a settlement obtained. It may take months or years to do this, but in most cases a judgment can be collected if it is properly followed up. After a judgment is obtained a transcript of that judgment can be filed in the upper court, and a lien thereby created upon any real estate which the debtor owns in the county.

One great difficulty in the collection of physicians' accounts for small matters, say under \$200.00, where the suit is begun in a Justice Court, is a trial by jury. In a Justice Court the jury are Judges of the law as well as the facts, and as a general proposition the jurors are rather poor specimens of humanity. An appeal is always made to their prejudices, and the doctor stands about as much chance ordinarily before such a jury as the traditional snowball in the hot place.

I might say in passing, however, that out of an average of over three thousand Justice Court suits a year which my firm has handled upon physicians' bills we have had about four or five trials by jury within the year. Nevertheless, the physician does not always lose his case, but the chances are that he will. He may, of course, remedy this by taking an appeal. The reason this method is not resorted to oftener than it is is that the person calling for a jury, who, it is needless to say, is always the defendant, has to advance the fees to the jury of \$6.00.

Of course, there are other little tricks that are resorted to before a jury, such as having a good old Irish mother come into court with the

usual rusty looking black shawl around her head and deny in a quivering voice everything the doctor says.

I recall one case where the defendant, a man, wept copiously from start to finish, but in this case he must have overdone the matter, for it seemed to arouse the sympathy of the jury for the physician, who was given a verdict for the full amount of his bill.

As to whether or not it always pays to sue, it must be remembered that suit is generally resorted to only as a last resort, and the experience in our office has been that upon a conservative basis from 75 per cent to 80 per cent of the judgments obtained have been collected.

There seems to exist in the minds of many physicians the idea that their appearance in court is not necessary; that if they simply make an affidavit, and then send their books, that is sufficient. Proof must always be made upon any claim where it is contested; it makes no difference whether the claim is for \$5.00 or \$5,000.00, the same rules of practice apply, and when the suit is contested it is necessary for the physician to be present and to testify to the services he rendered, introduce his books, etc.

Under the bankruptcy law a man may go through bankruptcy by filing his petition in the United States Court, claim his statutory exemptions, and, if he has no more than the statute allows him, the persons whose claims are scheduled have absolutely no recourse. To my mind, this law is very unjust and improper, but so long as Uncle Sam wants to put his O. K. on the dead beats there is nothing that can be done.

The husband and wife in this State are both liable for a physician's bill, and, in fact, for all family expenses, and they may be sued together or sued separately.

Where the husband goes through bankruptcy it is generally an advisable thing to sue the wife, if there is one, and as a general proposition if the husband cannot be collected from it is a good thing to sue the wife, for in a great many instances the husband puts all his property in his wife's name, and in a case of this kind the bill can readily be collected.

The garnishment law in this State is bad. A married man is entitled to a weekly exemption of \$15.00 per week, and the employer may pay the employee in advance if he chooses, even though he does so for the express purpose of defeating a garnishment suit. In some States garnishment laws have been passed quite recently which permit a creditor to garnishee from 10 to 25 per cent of the amount that the debtor earns. This, to my mind, is a very fair and equitable provision, and affords protection to the physician that is not given to him in this State.

I believe that if the Physicians' Club would, in conjunction with the medical profession in general, take proper steps before our next Legislature to have a law of this kind passed that they could do it. If such a law as above suggested were in existence in this State it would be valuable for the moral effect that it would have upon the debtor. Where a man is earning only \$15.00 a week he knows that he cannot be touched by garnishment, and if he stands in with his employer he does not care a fig whether you garnishee or not, and if he is earning \$100.00



and his employer sees fit to do so they can make arrangements together whereby the creditor cannot collect anything from him. If the 25 per cent law was in effect in this State, I believe that it would be unnecessary to resort to garnishment except in extreme cases, or even sue a debtor. He would know that he would have to pay a certain amount if garnisheed, and to save the costs and trouble of such proceedings, would make amicable arrangements to settle.

Don't get cold feet the minute one of your ex-patients says he will sue for malpractice. If all the threats made to us of malpractice suits were carried into effect it would take the courts of Cook County at least a solid year to try them. I only have personal knowledge of seven or eight malpractice suits within the last ten or twelve years since my connection with the collection of physicians' accounts, and only know of one instance where a verdict was actually rendered against the physician, which case I think was afterwards reversed by the Appellate Court.

A rascally patient knows that a physician does not want to be sued for malpractice, and they think the cheapest and easiest way to pay a bill is to threaten such a suit. A suit for malpractice must be begun within two years. If, however, the physician sues upon his bill and in that suit the defense of malpractice is set up it is a bar to a suit against the physician for damages. This question has arisen occasionally in matters in our office, and as a result of it we have had some malpractice suits dismissed.

I recall with a great deal of pleasure what one physician instructed me to do when I told him he was threatened with a malpractice suit. He instructed me to offer the man \$13.00 for costs to begin that suit, which I did. The man on his part immediately became weak-kneed and settled the bill. He was bluffing, and my client had nerve enough to call his bluff.

While we are discussing the question of malpractice, the thought has occurred to me that the physicians themselves could very profitably run their own company, bonding themselves against malpractice suits. As it is now, I believe there are one or two bonding companies operating in Chicago who charge an annual fee on an average of about \$25.00, and agree to defend a physician in the event of a malpractice suit being instituted. Why would it not be a good idea for the Physicians' Club to take the initiative in this matter, form a corporation for this purpose and thus protect themselves against malpractice suits? I believe that such a corporation would meet with favor among physicians, and after the first year or two the fee could be very materially reduced.

I think there are about five thousand physicians in Chicago, and if one thousand of them could be interested they would in a very short time accumulate a large surplus which could be distributed as profits or used to reduce the annual fee.

Possibly physicians do not desire to bother with business matters, but with their support and the company run on a proper business basis I do not see why it would not be successful. It would also serve to draw the physicians a little

closer together among themselves, and the probability is that fewer malpractice suits than ever would be commenced.

In closing, I desire to thank the members of the Club for their hospitality, and I sincerely hope that the occasion this evening has proven as enjoyable to them as it has to me.

Hugh T. Patrick, who was on the programme to speak to the topic, "**Fees and Collections in Relation to Special Practice,**" did not present a paper, but addressed the meeting extemporaneously. He said he could not see why specialists should be set apart as a separate class in regard to the matter of fees and collections. With the rest of the profession they had the same problems to deal with. Fees, like everything else, must yield to the simple law of supply and demand. The size of the fee is not a question of what a specialist thinks he ought to make it, but what he can get, as it were, in the open market. What he does command is, in the long run, just about what he is worth. His price, so to say, is not set by himself or his conferees but by the public to whom he offers his services. The price is dependent upon the valuation that the public puts upon his services. The people, in the long run, are not often far wrong. They may be in error when gathered into an excited mob or when their momentary opinions are taken, but when they are given time they pretty generally value a man just about at his actual worth. They may be in error in regard to his technical attainments as they may at times overvalue a mere trickster and commercial advertiser. But in regard to the management of his financial affairs a physician needs to have tact and business acumen as well as technical knowledge to get the best out of his profession. The public judges the whole man and not the doctor alone. A man's earning capacity is dependent upon his valuation in the eyes of the public. As a whole, the big fees we sometimes hear of are fees actually earned; not always, of course, in accordance with the actual work done but in accordance with the value of the man in the eyes of the community. To earn these big fees, therefore, a man must be a good business manager as well as a good physician. He must let people know in a legitimate way that he has special ability; that in his special work, the result of special opportunities for study, he has a good, perhaps a superior commodity to offer them. If he is not false but actually has the commodity and is adroit in letting the community know it he will be that much more valued by the people and will command correspondingly higher fees. The general practitioner does well to protect the specialist in commanding and collecting his larger fees, for the higher the value the laity put upon the consultant and specialist the higher will be the value put upon the general practitioner. Hence the family physician indirectly benefits himself when he insists upon the specialist being given exactly what is due him on account of his superior attainments. The estimate put upon the services by the patient is thus elevated both in behalf of the specialist and the general practitioner. On the other hand, it is grossly unjust and impolitic to take advantage of the ignorance of the patient and charge a fee out of all propor-



tion to the accepted value of the services rendered. Insignificant services should most emphatically not be charged large for because forsooth the patient has no means of determining their real value. Common honesty is the best policy here as elsewhere.

Here the speaker cited a number of cases, known to him, illustrating how very unimportant services were charged for because the attendant thought he had a good thing of it in an ignorant and willing patient. In the end all such practices lead to loss of prestige and custom; and when he who does such is accidentally found out, as he sometimes is, the net result of the practice proves disastrous in the extreme. A damaged reputation leads to a rapid loss of patients and ultimately to a complete want of practice. The speaker declared that he believed patients who came a long distance to consult a specialist ought to be asked to pay a good, large fee. If they valued the specialist's services to that degree as to put themselves to all the inconvenience of traveling many miles, and even bringing with them a host of relatives, nurse, etc., those services should be charged for in direct proportion to the high value thus shown to be placed upon them. The same holds true if the specialist is asked to go a long journey to see a patient in his home. Again, if a patient goes to a large hospital and insists upon having a private room, with all its special conveniences and, a private nurse, he ought to be made to pay a goodly fee to the physician who is attending him. If he refuses to pay he ought to be sent to and regarded as a general ward patient. The speaker said he now made this his invariable rule, namely, never take a fee from a ward patient, and to always insist upon one from a private room patient. He believes this to be just and to the advantage not only to the specialist and the hospital interne but to the great body of the profession as well. It keeps up the idea with these patients who are insistent upon having all the comforts of a private room that medical services have a monetary value and must be paid for.

Sometimes the general practitioner allows himself to commit the folly of speaking of the specialist's fee as robbery, injustice and extortion. By so doing he hurts himself in the eyes of the community even more than he hurts the specialist, and moreover it is unfair and unjust. An amicable adjustment of all such matters should be striven after and not the expression of such untrue and impolitic charges.

Finally, in regard to the matter of collecting fee, it should be inculcated into the minds of the laity that the money earned by the doctor belongs to him the moment the service is rendered. The fee is not due at the first of the month, next week or at the end of the year. It is due the moment the consultation or operation is completed. Hence the fee should always be paid in cash, especially for office and ordinary home visits. Only very exceptional circumstances ought to be allowed to interfere with this rule. Cash practice is the best, and should always be insisted upon. If here for any special reason the patient cannot present the fee immediately, a bill should be sent out promptly. Even in prolonged spells of sickness,

as often occurs to the family physician to treat, it is best that regular, frequent small payments should be made on account, rather than that a huge bill should be presented after many weeks have gone by. The advantage of this is obvious, and with a little tact and insistence the practice can be carried out much more than is now usually done.

The amount of a fee and the reason for charging it should be explained, if possible, to the patient before the service is rendered. All will go well then. It is the same here as in business; a man always likes to know beforehand what he is expected to pay, and why. It tends to produce a better feeling between the patient and his medical adviser.

A. P. Clark Matson, Esq., a guest of the Club, was invited to open the general discussion. He spoke of the advantage of being prompt in sending a patient his bill, and in being insistent upon its payment at once, or within a reasonable time. If the bill is not attended to and all conciliatory measures have been exhausted, he believed that a suit for judgment should be promptly begun. It is right and not in the least undignified for a physician to sue for a bill. Hospitals have a great deal to answer for in developing the desire among people to get their medical services for nothing. Among the wealthier people the hospital is looked upon as a sort of boarding house where he can stay awhile instead of his own home while undergoing medical treatment. With many the idea obtains that the entrance into a hospital is synonymous with the cessation of all doctor's fees. Hospital patients, when able, should always be made to pay. The charges should be made to cover the surgeon's and specialist's fees.

Another point that ought to be more strenuously inculcated into the minds of the people is that when a consultation with a specialist is called for the family physician or attendant calling the consultant acts as the agent of the patient and not as the agent of the consultant. This is his legal status, and for many reasons should be carefully remembered.

Frank Billings, the next speaker, said he had learned many things from the discussion of the topic. He agreed with Dr. Patrick that a man usually gets, in the long run, just about what he is worth. He gets, so to say, his market price, and that generally is about all that he actually earns. By this is not meant that a man gets a fee always commensurate with his technical skill and ability. Many a well-trained man technically is lacking in good business sense and tact in showing his worth to the community. Therefore when it is said that a man gets what he is worth it is meant that his income proportions itself in direct ratio to the whole man's worth and standing in the community. The variability of fees depends upon many factors. Two of the more important of these factors are the variability of the patients' power to pay and the variability of the personality of the practitioners. Both of these factors must be given due weight in calculating the relative size of medical fees. That this is true is shown by the fact that big fees do not continue when there is poor skill on the part of the practitioner. These men are like meteors, they

are not durable; and both their careers and their big fees soon come to an end. This is a matter of common observation. One of the preceding speakers had remarked that the rich pay too small fees, relatively, and the poor too large. That may in part be true, but as far as the fees paid by the rich, two factors exercise a controlling influence, namely, the character of the service rendered and the personal manner with which one approaches them. As for the speaker, he declared that his relationship with the wealthier members of his clientage had always been of the pleasantest and most satisfactory sort. He had never experienced that they, as a class, paid fees that were too small. Early in his career he began being systematic in the management of his accounts, even employing a regular bookkeeper to issue his bills and keep his books. In other words, he adopted a strictly business method and adhered closely to it. He had found this not only time-saving and advantageous, but it gave satisfaction to his patients, most of whom were business men and appreciated system and exactness. In his financial dealings with the rich it had often been his experience that he was offered a fee largely in excess of that which he had asked. Hence his yearly cash balance was always larger than the showing of his book accounts. This was one of the pleasant experiences which he had to testify to in relation to his dealings with the wealthy as compared with the poor. In accordance with this excess he correspondingly reduced his accounts with the poor. Though always pressed for time, he had never made any distinction between rich and poor who consulted him in regard to the care and time that he gave to the patients' examination. A waiting maid was given just as much care as the wife of a millionaire, though the charges for services rendered were different. Here the speaker cited a number of interesting and instructive personal experiences. Like all practitioners, he had had his share of troubles with the deadbeats, though now he sees less of them than formerly. Collections from them are always bad, and when he found he had one to deal with he placed the bill promptly in the hands of the collector with instructions to give the deadbeat a hot chase. In twenty-two years of practice he had not had more than sixteen distinct complaints in regard to the bill; but on the other hand he has had it occur a hundred and sixty times to have the debtor say that he would like to increase the fee beyond what the bill called for.

In a humorous manner, **H. S. Christopher** declared that he had attended the meeting to learn something, but that as a matter of fact he had absolutely learned nothing. He felt that he had always been so lax himself about the management of the financial side of his practice that he came in fear and trembling, expecting to sit the whole evening upon the gridiron. And he had been sitting on the gridiron, but he suspected others were in exactly the same boat. He was delighted with all that had been said about system and orderly accounts, and big and little fees, etc., but after all he feared he would go home and continue in the same old way.

**Joseph Zeisler** said this was like a good, old-fashioned experience meeting, but that it was good for doctors to get together thus once in

awhile and compare notes. What he would like to know, however, would be how to diagnose a deadbeat. He would be grateful to anyone who could tell him the exact signs whereby he can detect a deadbeat with even half as much precision as he can detect a dermatological case. As for himself, he knew of no signs, though he suspected a few. For instance, look out for the man who comes to your office, gets your advice and then suggests that the bill be allowed to run on until the disease is completely cured. He is apt to be a deadbeat, and with such patients it is best to explain at once that it would be better all round if each visit were paid for in cash. He believed that the attending physician should always make it a rule to instruct the patient who needs consultation to pay the consultant his fee in cash at the time of the consultation. Neglect of this had put him to not a little inconvenience at times. At the request of one of the members, the speaker repeated his well-known aphorism, namely that the big fee is always the normal fee, while any reduction from that is a concession to the patient and his circumstances.

**Harold N. Moyer** said he had come to the meeting like the man of whom the following incident is related: He had fallen into the lake. When he was rescued and dried some one sympathetically asked him how he had come to fall into the lake. "Come to fall into the lake!" he exclaimed; "why, my friend I didn't come to fall into the lake. I came to fish in it." Dr. Moyer said he felt like Dr. Christopher, that after all he hadn't learned very much from the discussion. As for himself, he never kept any accounts or books. His business was all put on a cash business. It was less trouble, and his patients soon learned the system. He saw no good reason to change his method, after hearing the discussion to-night. If a patient leaves without paying for the visit he mails a bill at once, so quickly even that the bill may be awaiting the patient at his home. If it is ignored he does not attempt to collect it or send another bill. If the patient comes back he recognizes his position and either pays cash charges thereafter or ceases his visits entirely, either of which is more agreeable to the speaker than the keeping of books and dunning for unpaid accounts.

**M. H. Cazier** dwelt upon the fact that money does not constitute the whole of a doctor's fee. There is the gratitude of the patient and the conscientiousness of a good deed having been done. When this fact of the fee is omitted, the loss is more keenly felt than when the few dollars that constitute the rest of the fee are not paid. Life, after all, is what we make of it. Its fees are valued in accordance with our point of view. The general practitioner does more hard work for the pay that he gets than probably any other man. His fees are relatively small. Therefore he must look to something else in addition to round out his reward. This additional something is the gratitude and affection of those whom he has brought through their trouble.

**C. W. Courtright** declared that we had heard a lot that everybody had heard before. And yet it was good to reconsider from time to time these matters. The topic appeals especially to the family physician more than to the consultant surgeon or specialist. The speaker advocated fixed rates, such as the trades unions adopt.



He believed it would be good business, not unprofessional and greatly to the advantage of the doctor's bank account. Such charges, as say from \$50.00 to \$5,000.00 for a given operation were ridiculous, and yet that is the way most of our fee lists read to-day. Another source of injury to the professional income is the gratuitous treatment of patients able to pay in the hospitals. This is absolutely wrong, and is most unjust and unfair to the outside general practitioner. More cohesion and closer organization of the profession are needed, so that established fees may be decided upon and charges uniformly charged. The speaker said he had posted conspicuously up in his office certain hints and suggestions in regard to his financial relationship with patients. They were in the nature of certain business axioms, and he believed they did good by being there upon his walls.

James W. Walker urged that all accounts, whether large or small, be collected. He believed it was injurious to patients and the profession alike to allow accounts to lapse and go unpaid. No bill should be considered too small to collect. And above all, suit, vigorous and prompt, should be instituted against all deadbeats. They should have no mercy shown them. We should in this and in other ways educate the people to the fact that doctors must be paid. The speaker did not approve of a blacklist, but he emphatically believed that every physician should inform privately all his medical acquaintances of a deadbeat by whom he may have been caught.

W. T. Stewart took exception to the way that the courts—as, for instance, the Probate Court—arbitrarily determine the proper fee a physician ought to charge for his services. All court fees are too small and are far under what the average attorney gets for rendering equivalent services. A physician is liable to be called into court at any time. The Club ought to agitate this whole question of medical fees for testimony and services in court.

L. Harrison Mettler,  
Official Reporter.

The Chicago Surgical Society met November 3, 1902, A. J. Ochsner, M.D., in the chair.

E. J. Senn reported a case of recto-vesical anastomosis for exstrophy of the bladder.

He exhibited the patient two years ago before the Chicago Medical Society, at which time discussion arose as to the prognosis. He showed the patient now for the purpose of demonstrating the possibility of performing vesico-rectal anastomosis successfully, and without causing infection of the kidneys. Two years ago he made an anastomosis between the bladder wall and the rectum. Examination of the urine before the operation showed considerable albumin and granular casts; at present the urine shows no albumin, but a few granular casts; specific gravity, 1015; reaction, slightly alkaline.

He modified somewhat the procedure described by Jacob Frank, in that he made the anastomosis similar to the manner in which one would make a colostomy. He described the various steps of the operation.

As regards the mortality, he thought it would

be no greater than that from colostomy.

L. L. McArthur said he presented a case some years ago before the Chicago Medical Society similar to the one described by the essayist. The bladder was covered in by flaps from the abdominal wall. The median flap contained hair follicles, and in this particular case the hair grew and a phosphatic deposit occurred upon it and caused trouble. He asked Dr. Senn whether any trouble had arisen in his case from this source.

Dr. Senn replied there had not.

Dr. McArthur asked whether gases and fecal matter had escaped through the fistulous tract.

Dr. Senn said there has been a little trouble as regards fecal matter, small particles of it having escaped through the fistulous tract, also some gas, but when the patient took a laxative he had very little trouble.

Jacob Frank said that when the fistula now existing was closed, there would not be any trouble from the escape of feces, because he had found, in experimenting on dogs, that if he took the healthy bladder of the animal and anastomosed it with the rectum, while there was at first a severe vesical inflammation, when the animal recovered from the operation the bladder contracted and the vesical membrane took on the characteristics of the mucous membrane of the rectum, showing that the bladder could accustom itself to a foreign substance, and also to more or less infection.

D. N. Eisendrath asked how long the patient could hold the urine, and what effect it had upon the bowel movement, particularly where there was such a large quantity of fluid in the rectum constantly.

Dr. Senn replied that the urine did not pass into the rectum at the present time, owing to the defect. During the three or four days when the defect was closed, the bowels moved two or three times a day. He recalled a case in which the late Prof. Fenger did a Maydl operation, where the patient had two bowel movements a day.

A. E. Halstead said that if he had another case of exstrophy of the bladder to operate on he would resort to the same method that he employed in the first one, namely, doing a vesico-sigmoidal anastomosis with the button. He would use the Murphy button in preference to the Frank coupler. His reason for using the Murphy button in preference to the Frank coupler was that the former could be used to great advantage in shortening the time of operation; one could separate the two halves of the button, but this could not be done with the coupler.

L. L. McArthur read a paper entitled, "Renal Cystine Calculus, With Right Nephrolithotomy, Right Nephrectomy, Followed Later With Anuria, Requiring a Left Nephrostomy; Recovery."

The patient, aged 37, married, mother of two children, had been in poor health, but had no serious illnesses. Her mother died of liver and kidney trouble. Brother and sisters well. Very poorly for three years, complaining during that time of periodical vomiting, with right lumbar pain lasting generally three days, and occurring chiefly at the monthly epoch. The latter regu-



lar, usually of four days' duration. For years had suffered with constipation. Present attack began January 29 with some pain, vomiting, constipation, never jaundiced, fever as high as 101 degrees. Quite recently a tumor was discovered by Dr. Waller in the right lumbar region, which examination revealed to be an undoubted renal tumor. Diagnosis: Stone in kidney, with pyelitis. Advised X-ray picture, urinary segregation and probably nephrolithotomy. June 2nd, skiagraphs showed two stones in right kidney. Left kidney negative.

The writer had selected this subject more to share what he had learned in his search of the literature than to exhibit a successful surgical interference. The majority of surgeons had looked upon cystine and cystinuria as chemical and medical curiosities, without special significance. The history of the case presented showed the fallacy of the same. Few realized that cystine probably shortened the life of those afflicted with it, since three cases only were reported after the age of fifty, and its rarity was a matter of comment, since only 112 cases had been reported since its discovery in 1805. Cystine was probably the sulphur-containing fragment split from the albuminoid molecule, either by a faulty metabolism in the liver, or a purefective change in the alimentary canal. Somewhat soluble in water, like uric acid, it may, when in concentrated solution, be precipitated in hexagonal crystalline plates and, thus precipitated, may form a calculus in the kidney or bladder.

Probably the most striking fact in connection with cystinuria was its marked hereditary tendency. Golding-Bird reports having seen the trouble in three generations of the same family, and Cohn in a family of twelve people reports seven, the mother and six children, as having the disease. Many other instances of like character are on record. Simon, of Johns Hopkins, has, more than any other, brought to systematic notice the entire literature of this disease.

When Bauman and Udransky discovered the presence of cadaverine and putrescine in cases of cystinuria it seemed to offer an explanation of the cystine production as the result of putrefactive processes somewhere in the alimentary tract, and the presence of the same, in the feces of the patient, apparently confirmed this idea. But while these diamines have been found during cystinuria, they have never been found associated with any other condition, and only five or six well authenticated cases out of the 112 are known. Moerner has obtained cystine abundantly by the digestion of horn with hydrochloric acid, and Embder has prepared it from egg albumin by hydration. It has been found in the liver in poisoning by phosphorus; it has been found associated with alcoholism, and has been prepared by artificial pancreatic digestion. Dr. McArthur believes, therefore, that since it can be demonstrated to be produced under these several conditions, we may find cystinuria due, at one time, to poor metabolism; at another, due to chemical poisoning, and at another, as the bi-product of bacterial putrefactive processes.

Dr. McArthur presented the woman upon whom he had operated, for the purpose of showing the lateral curvilinear incisions following

along the margin of the twelfth rib, in the particularly thick wall of the patient, to demonstrate that there is no hernia present in the case illustrating his paper.

A skiagraph was obtained, showing what appeared as a calculus in the pelvis of the kidney; another one in the ureter of the right kidney, but nothing was seen in the left kidney. These stones having been demonstrated to have been present, the patient was admitted to St. Luke's Hospital on the 8th of June, 1901, and left the hospital July 13th, six weeks later, having had performed a nephrolithotomy of that side. On opening the kidney, innumerable small calculi, a few of hazelnut size, and others of the size of very fine millet seeds, with a good deal of white, creamy material, came away, and the stone, which the skiagraph had shown in the ureteral orifice, was removed. Because of the creamy, purulent-looking contents and great number of fine particles, it was not deemed wise to close the kidney, so a drainage tube was inserted. On the 13th of June the wound was reported as healing by first intention, except at the part where the drainage tube rested. On the 8th of July the patient was able to leave the hospital. A small drainage tube was still in the side, with a small amount of urine escaping, the urine at that time being normal. The urine at the time of the patient's admission to the hospital was purulent, and by segregation showed purulent material coming down from the right side, and not from the left.

On June 16th, and from that time on, memoranda were made on the urinalyses as they were submitted of the presence of cystine crystals in the urine, attracting no more attention than the fact that they were there.

In October, the wound not having healed, she returned, as he had suggested. Very little urine was escaping from this fistula, and nothing came down from the ureter. She came in October to have the kidney removed. X-ray negative at this time. On opening the kidney he found another stone had formed and was blocking the ureteral orifice. Rather clear urine was in the pelvis of the kidney; the tube was not in the pelvis of the kidney. Finding another stone, he decided to give her another chance to save the kidney, which resulted in the return of the patient in February, 1902, for final nephrectomy. This was done on Feb. 5, followed by as normal a convalescence as could be desired up to about midnight of the twelfth day. The patient having the stitches out, the wound healed on the right side. Having had a rather full meal, she said it did not taste right, that it was spoiled, and she complained about it that evening. At 2 o'clock that night she was suddenly seized with vomiting and an intense pain of a renal colic character upon the left side, followed by a gradual suppression of urine, the kidney having been functioning normally for ten days after the right nephrectomy. The urine came down in about twenty or thirty drops in two hours, as determined by the catheter. She was vomiting, and became so depressed he decided it was necessary to make a nephrostomy on that side. Upon opening the kidney he found a distended pelvis. Under tension, the kidney was somewhat enlarged, very hard and firm. As

soon as the finger was carried through the cortex urine gushed out under great pressure, containing nothing but a few crystals of cystine. No stone was to be felt, nor was there any stone passed from that side. But thirty-six hours afterwards there began to come down through that ureter a perfect shower of cystine crystals, which he is convinced was the cause of the occlusion of that ureter. As soon as the kidney was relieved of its obstructed lumen it began to secrete again. The quantity of urine in the first twenty-four hours afterwards was sufficient to saturate the bedding and mattress of the patient. As soon as we were able to collect it all, fifty-seven ounces on the third day were excreted.

Arthur Dean Bevan spoke of the relationship between the existence of one working kidney in an individual and the occurrence of complete anuria. When anuria developed it did so in a patient who had but one working kidney. It was certainly rare to have obstruction of the two ureters occur simultaneously. In this particular case one kidney had been removed, and therefore there was but one working kidney, and obstruction of the ureter of that kidney would develop the symptoms described. He thought if surgeons were to keep track of the function of the two kidneys in cases of kidney colic they would find that temporary anuria of one kidney was the rule.

Dr. McArthur, in closing the discussion, urged the Fellows, if they encountered such manifestations in the urine as he had in his case, not to pass them by as a mere chemical curios, but to pay attention to them, or be on the lookout for them.

Dr. Wm. Hessert read a paper on "**Dislocation of the Individual Carpal Bones, With Report of a Case of Luxation of the Scaphoid and Semilunar.**"

The patient, aged 25 years, painter, June 12, 1902, while at work on a scaffolding, lost his balance and fell a distance of four stories, his fall being interrupted by several obstructions before he finally struck the ground. He was taken in an unconscious condition to the hospital, where it was found that, except as to his right arm, he was practically uninjured. The injury of the arm was diagnosed as fracture of the lower end of the radius, and the member was put up in splints. In July, when Dr. Hessert first saw the patient, it was then four weeks after the accident. The splint had been but recently removed, and the patient still complained of disability of the right wrist and hand.

On examination the fingers were found to be held somewhat flexed; he could not pick up any object, neither could he make flexion nor extension of the fingers. On passive motion the fingers could be extended and fairly flexed, but the movements were painful. Pronation and supination were free, both active and passive. Active and passive motion at the wrist was very much restricted. There is a bluish star at the middle of flexure of wrist about two centimeters in extent. The dorsal surface of the wrist and forearm presented no abnormality. On the palmar surface of the wrist, and to the ulnar side of the median line, was noticed an oblong swelling about four by two centimeters, whose upper pole could be more readily outlined than

the more deeply situated lower end. The lower pole of the mass could not be outlined definitely, owing to the superimposed flexor tendon. The upper extremity was rounded, extending about four centimeters above the level of the styloid process of the ulna. The proximal (upper) extremity of the mass was slightly movable; the distal end was so deeply embedded that it was hard to say if any motion could be imparted to it or not. No sensory disturbances of the fingers, but considerable atrophy of all the small muscles of the hand, and some atrophy of the forearm.

The X-ray revealed the nature of the trouble, and clearly showed that the author had to do with the displacement of two bones, the scaphoid and semilunar, to a place far distant from their original location.

Replacement of the bones by manipulation was out of the question. A longitudinal incision two and a half inches long, midway between the tendon of palmaris longus and flexor carpi ulnaris was made. After dividing the fascia the tendons of the flexor sublimus digitorum and the flexor profundus digitorum were drawn to the radial side by a blunt hook. Flexor carpi ulnaris, together with ulnar artery and nerve, were retracted in the opposite direction. The bones were easily accessible, lying on the pronator quadratus. The semilunar was more deeply situated and nearest to the wrist joint. It was still partially attached by ligaments. The scaphoid was more superficial and was attached to its fellow by a few bands. Both bones were easily enucleated, after which the wound was closed by silkworm gut sutures. The wound healed by primary union. There was no evidence of pressure on or stretching of nerves.

The patient was exhibited and the subsequent history of the case given, showing that the essayist had obtained an excellent result.

The author went extensively into the literature of the subject, quoting the number of cases of forty-nine authorities.

A. D. Bevan had several cases diagnosed as partial dislocations of the os magnum, but never observed a forward dislocation of any of the bones of the carpus. He had made fifty or more Colles' fractures on the cadaver, and then made dissections of the injury done after the fracture was produced. In the fifty or more cases of Colles' fracture which he had produced experimentally he had never seen a single dislocation of any of the bones of the carpus, either a dislocation of the wrist, that is, between the radius and ulna and the first row, or between the two rows, or between the second row and the metacarpal bones. Injuries made in this way had invariably been fractures of the radius or ruptures of the ligaments without displacement, and sometimes not infrequently a fracture of both the radius and ulna at the lower end, but never a dislocation of the carpal bones themselves.

Dr. Hessert, in closing the discussion, expressed the belief that dislocation of the carpal bones was of more frequent occurrence than was formerly supposed. With the advent and use of the X-ray he thought more of them would be detected in the future, although this dislocation might be considered a comparatively rare one.



**"Inflammation and Perforation of Meckel's Diverticulum as a Cause of Septic Peritonitis, With a Report of Two Cases of Typhoid Perforation of Meckel's Diverticulum.**

A. E. Halstead read a paper on this subject, in which he said that persistent omphalo-mesenteric remains may produce symptoms in a number of ways, depending upon their degree of completeness. Of the pathological conditions arising from these remains the most important are:

1. Intestinal obstruction, either acute or chronic.

2. A free diverticulum, that is, one attached to the intestine alone, may descend into a hernial sac, and then by its presence complicate this condition.

3. The intestine above an attached, patent diverticulum may become invaginated into the diverticulum, or its mucous membrane may become prolapsed, forming a tumor at the umbilicus.

4. When, as in the most complete form of this defect, the diverticulum forms a tube opening freely at the umbilicus we have a fecal umbilical fistula.

5. Cysts of diverticulum origin at times formed in the abdominal wall in the vicinity of the umbilicus, or intraperitoneal, either connected or disconnected with the intestines. Those that develop in the abdominal wall are usually pro-peritoneal or subcutaneous, within or near the umbilical scar.

6. In addition to these cystic tumors, solid adenoid growths are occasionally found about the umbilicus, which are no doubt related in their origin to remains of the vitelline duct. These have been termed by Lannelongue, diverticular adenoid tumors.

7. A Meckel's diverticulum may become the seat of an acute or chronic inflammation. Acute inflammation may lead to perforation, with local or general septic peritonitis. When the inflammatory process is chronic, thickening of the diverticular walls with circumscribed peritonitis will result, as in chronic inflammation of the appendix and gall bladder.

In the paper, cysts of diverticular origin and acute and chronic inflammations of this structure were considered.

After going extensively into the literature of the subject, the author stated that inflammation of Meckel's diverticulum may result: (1) from participation of the mucosa in a general inflammatory process involving the mucous membrane of the intestine; (2) from local causes, as obstruction of the lumen from twisting or kinking of the neck, or from foreign bodies and fecal concretions which may lodge in this pouch. Trauma also appears to have been the exciting cause of inflammation in some of the cases reported.

The following case occurred in the author's service at the Cook County Hospital, perforation of a typhoid ulcer in a Meckel's diverticulum in the fifth week of the disease being the cause of a fatal peritonitis:

Male, aged 26 years, had been treated in the medical wards of the Cook County Hospital for typhoid fever for four weeks. During the last two weeks the disease had pursued a very severe course, with high fever, excessive tym-

panitis and intestinal hemorrhages. On November 16, 1901, the patient was suddenly seized with severe abdominal pain and vomiting, and quickly passed into a state of collapse. In this condition he was transferred to the author's service for operation. The abdomen was opened under spinal anesthesia five hours after the onset of the symptoms of perforation. The peritoneal cavity was filled with liquid feces and pus. On examination of the intestine a deeply congested loop of ileum was seen in the right side of the abdomen. This was brought out and attached to its convex border; about three and one-half feet from the ileo-cecal valve was seen a Meckel's diverticulum two inches in length and having a diameter equal to that of the ileum. In the tip of the diverticulum was a perforation large enough to admit the tip of the finger; from this escaped intestinal contents. This was closed with silk suture, the abdominal cavity was flushed with decinormal salt solution, and after search for other perforations the abdomen was closed with drainage. The patient's condition appeared to improve during the operation, and for a short time afterwards, but later the heart began to fail and he died eighteen hours after the operation. Autopsy showed numerous typhoid ulcers, but no other perforation.

In reviewing the histories of the reported cases of inflammation of Meckel's diverticulum, the author finds that in none was the cause of the symptoms recognized before the abdomen was opened. In the cases operated upon, the diagnosis of appendicitis or of intestinal obstruction was made. At the present time no symptom or group of symptoms are sufficiently characteristic to permit of a diagnosis of diverticulitis. In the majority of cases the disease runs a course closely simulating appendicitis. In many the diverticulum occupies a position in the right iliac region close to the appendix. The onset is usually sudden, with vomiting, muscular rigidity and pain, as in appendicitis. In a few cases the symptoms have been those of recurring appendicitis, with the interval between the attacks free from any evidence of disease. In those cases when the diverticulum is attached to the umbilicus, periumbilical pain and tenderness are evidence of the disease being located in a Meckel's diverticulum. The presence of an umbilical fistula, tumor or cyst is presumptive evidence of other omphalo-mesenteric remains which may be the source of infection in circumscribed or diffuse peritonitis.

Dr. Bevan said he had seen some cases in which the remains of the vitelline duct persisted and gave evidence of trouble. He recalled two cases of obstruction of the bowel produced by the remains of the Vitelline duct, but he had never had a case of diverticulitis in his own surgical work, unless he had one at the present time. A woman was admitted to the hospital with a suppurating fistula at the umbilicus. A large, pancake-shaped abscess about six inches in diameter was found on opening the abdomen, into which the fistula ran. The abscess was situated between the parietal wall and omentum. It was filled with pus, and in the pus was a fragment of wood that was about a third of the size of an ordinary toothpick, which was macerated. From the location of the condition and from the



foreign body found it was undoubtedly a case of perforation of the remains of the vitelline duct from the wood which eventually perforated at the umbilicus.

He spoke of two cases of diverticulitis occurring in the practice of a professional friend.

Dr. Halstead, in closing the discussion, said that he encountered a case of intestinal obstruction from a diverticulum, and then shortly afterwards, probably within a month, he had a case of typhoid perforation of a diverticulum, and after seeing another specimen in the hands of William E. Schroeder, he thought the subject was well worthy of the consideration of the Society. A. E. Halstead, Official Reporter.

The Chicago Pediatric Society held its first regular meeting for the Society year of 1902 and 1903 on October 14, in Schiller Hall, with the President, M. P. Hatfield, in the chair, and the following members present: M. P. Hatfield, J. C. Cook, S. J. Walker, F. M. Belknap, F. M. Allen, M. B. White, J. W. Vanderslice, A. C. Cotton, E. R. Morse, F. X. Walls, J. D. Merrill, E. M. Moore; and as visitors, Drs. Rutledge, Mantor and Golden.

Minutes of the annual meeting were read and amended, and adopted as amended.

President Hatfield gave as an inaugural address, an interesting paper on "Diet Kitchens." This was followed by a paper given by I. J. K. Golden, the subject being "Artificial Feeding of Infants."

A general discussion followed the regular programme, after which Dr. Cotton moved that a committee of five be appointed by the Chair, to consider the subject of Diet Kitchens, and to report at the next regular meeting of the Society. There being no further business, the Society adjourned.

Emma M. Moore, Official Reporter.

The Chicago Pathological Society held its regular October meeting, Maximilian Herzog in the chair. President Herzog delivered as his address a sketch of the life of Rudolph Virchow. Virchow was declared to be the most conspicuous figure in the history of medicine of the second half of the nineteenth century. Victor Baccus reported, from the laboratory of the Chicago Polyclinic on **sarcoma of the ovary**. This study was based on four cases operated on by Prof. Henroten.

H. Gideon Wells reported on a **Fatal Pulmonary Embolism during convalescence from a simple appendectomy**. This occurred in the case of a real estate dealer 50 years of age, taken suddenly in the afternoon and operated by M. L. Harris the same night when an appendix that contained gangrenous spots was removed, a few days after the operation he had a sudden attack of pain in the right side of the chest posteriorly. Fifteen days after the operation he felt well and was allowed to sit up. The following night he died suddenly. Post mortem revealed a pulmonary embolism but careful search failed to reveal the site of the original thrombus. C. S. Williamson in discussion regretted that all veins of the legs were not examined and Wells regretted that no examination was made of the varicocele. The anatomical diagnosis was:

Embolism at the bifurcation of the pulmonary artery with consecutive thrombosis. Hemorrhagic pulmonary infarct in the right lower lobe. Hypertrophic pulmonary emphysema. Hypostatic congestion in both lungs. Limited fibrous pleuritis. Hypertrophy of the left ventricle. Diffuse arteriosclerosis with nodular sclerosis of the aorta. Healed recent laparotomy wound. Amputation of the vermiform appendix with invagination of the stump. Recent fibrous adhesion about the cecum. Chronic interstitial nephritis. Calcified nodule in the mesentery. Left varicocele.

From the conditions found at the autopsy it would seem that some time during the patient's stay in bed after his operation, a thrombus formed somewhere in the venous system, and becoming dislodged it was carried to the bifurcation of the pulmonary artery. From the formation of the thrombus it would seem that the embolus was probably a cast of some smaller vessel or vessels, which caught at the fork of the artery in rider fashion, and did not obliterate the entire lumen at first. Subsequently secondary thrombosis occurred at this point until the lumen was closed to a degree incompatible with life. The chief point in question is the original site of the thrombus.

The Washington County Medical Society was organized in Nashville, November 29. Dr. Granay was chosen President and J. J. Troutt was elected Secretary. The Chair appointed R. A. Goodner, S. P. Schraeder and W. D. Carter a committee to draft a Constitution and By-Laws. As a full attendance was not had to-day, adjournment was taken until December 8, when a permanent organization will be effected.

#### THE CHICAGO MEDICAL SOCIETY.

##### The Progress of Organization of Cook County.

The following are the provisional boundaries of the District Societies of the Chicago Medical Society, with the physicians in charge of each: North Side, R. B. Preble, from the river to Graceland, and from the river to the lake; Ravenswood District, Albin Young, from Graceland Avenue to South Evanston, and from the lake to Wisconsin division Northwestern Railroad; Evanston District, W. L. Ballenger, from South Evanston to Lake County line; Northwest, M. H. Luken, from Chicago Avenue, north and west to the river, including towns along Wisconsin division Northwestern Railroad; West Chicago, L. Ryan, Chicago Avenue to Twelfth Street, and from the river to Austin; Auxplaines, W. R. Livingston, Austin and towns west to county line; Lawndale District, F. C. Honnold, west of Western Avenue to county line and south of Twelfth Street; Lake District, T. J. Sullivan, Twelfth Street to Fifty-fifth Street, and State Street to Western Avenue; Southwest District, F. R. Green, Fifty-fifth Street to county line and west of State Street to county line; South District, W. E. Schroeder, river to Sixty-third street and river to lake; South Chicago, A. W. McLaughlin, Sixty-third Street to county line and from State Street to county line.

Every member of the Society is keenly ap-

prelative of the needs of a thoroughly organized profession. On every hand whenever the subject is mentioned and the individual is requested to assist in perfecting organization, a more than willing response is invariably given. Listen to what some of the Committee say:

R. B. Preble informs us that the work of the Organization Committee is progressing most satisfactorily and the membership of the Society is increasing at a rate never before approached. There are now over one hundred men actively interested in this work, and to each one of these a very definite task is assigned. The work is hampered by the fact that there is no complete and accurate list of practicing physicians in Cook County, but the territory has been so subdivided that not many will be overlooked. No member of the Society should neglect any chance to further this work. If you know any reputable physician who is not a member, get after him. It will do no harm if a dozen urge him to join.

W. S. Harpole reports: On Friday, November 14, forty-five members of the Chicago Medical Society, residing on the South Side, held a meeting for the purpose of considering more fully the organization of a local Society, in accordance with plans now afoot for the establishment of local branches of the Chicago Medical Society. At this meeting a motion was carried as follows: That it be expressed as the desire of those present that it shall be the policy of the Chicago Medical Society to divide the county into districts and that those districts be closely those already outlined by that Society. That the district suggested by the Committee on Organization for the South Side be extended to Sixty-seventh Street on the south instead of Sixty-third Street. That it is the wish of those present to form a permanent local Society, believing that the Chicago Medical Society is unwieldy on account of its size. The following resolution was also offered and adopted:

Resolved, That we, members of the Chicago Medical Society, residing in the territory bounded on the north by the Chicago river, on the south by Sixty-third Street, on the east by the lake, and on the west by State Street, approve in its entirety of the plan suggested by the Committee appointed by the President of the Chicago Medical Society providing for a more general organization of the Society.

Officers were elected as follows: W. E. Schroeder, President; W. S. Harpole, Secretary; Geo. B. Dyche, Treasurer. The Executive Committee to consist of the President, Secretary and Treasurer and Henry F. Lewis, H. W. Cheney and Wm. E. Cuthbertson. A Committee on Constitution and By-Laws was appointed.

#### Marriages, Deaths and Changes of Address.

##### Marriages.

F. W. Blatchford, M.D., to Miss Frances G. Larned, Chicago, November 29.  
Harry D. F. Browning, M.D., to Miss Eda Kracke, Moline, September 17.

Edw. A. Corcoran, M.D., to Katherine W. McCarthy, M.D., of Chicago, August 28.  
B. F. Flanagan, M. D., Chicago, to Miss Katherine O'Connor, Springfield, September 10.  
C. M. Jacobs, M.D., of Chicago, to Miss Helen Thalheimer of Richmond, Va., October 27.  
J. E. Leahy, M.D., to Miss Margaret E. Slattery, Chicago, November 1.  
M. V. Lonergan, M.D., to Miss Mary E. Dresbach, Decatur, November 28.  
Samuel M. Lougeay, M.D., to Miss Carrie Burghard, Fayetteville, September 16.  
Samuel Moore, M.D., Danville, to Miss May Smith of Philadelphia, Pa., November 5.  
Enos E. Palmer, M.D., to Miss Florence Cook, Ottawa, October 22.  
Edmund P. Staff, M.D., to Miss Laura Shutt, Ramsey, October 5.  
O. H. Tuttle, M.D., to Miss Grace M. Goss, Chicago, November 24.  
John Archibald Brown, M.D., of Kankakee, to Violet H. Palmer, M.D., of Chicago, November 27.

##### Deaths.

Allen, W. C., Chicago, November 4, aged 37.  
Andrews, D. C., Pittsfield, formerly, September 25, aged 80.  
Angear, J. J. M., Chicago, November 8, aged 73.  
Bausman, A. B., Chicago, October 21, aged 46.  
Bell, J. J., Chicago, November 4, aged 41.  
Coggeshall, J. S., Palatine, September 4. —  
Cook, E. P., Mendota, October 30, aged 70.  
Conway, J. L., Chicago, October 7, aged 24.  
Cory, A. L., Chicago, September 25, aged 51.  
Eddelman, J. F., Chicago, September 19, aged 46.  
Fringer, G. W., Pana, November 18, aged 67.  
Miller, E. P., Sullivan, October 7, aged 37.  
Moyers, L. E., Fairdale, September 2, aged 38.  
Muffat, M., Palatine, September 30, aged 50.  
Steele, Harrison, Peoria, November 14, aged 66.  
Wiseman, L. J., Pontiac, November 9, aged 27.

##### CHANGES OF ADDRESSES.

##### Changes in Chicago.

Beck, C., 522 Dearborn ave. to 42 Roslyn Place.  
Clark, B. G., 162 W. 22d st. to 25 W. 79th st.  
Miller, Chas. H., 6341 Jackson avenue to 273 LaSalle avenue.  
Prendergast, Jos., 2007 Michigan avenue to 86 N. Park avenue.  
Sippy, B. W., The Winnemac to 3945 Ellis ave.

##### Changes From Chicago.

Barlow, T. H., to Wahoo, Neb.  
Becker, C. W., to La Grange.  
Cox, Frank, to Taylorville.  
Crowley, J. F., to LaSalle.  
Coburn, H. H., to Bristol, S. D.  
Dolan, A. M. J., to Cloquet, Minn.  
Fischer, Martin H., to Univ. of California.  
Hultgen, J. F., to Mt. Pleasant, Iowa.  
Harlan, H. A., to Oregon.  
Merrill, H. T., to Wahpeton, N. D.  
McGrath, to Grant, Neb.  
Olson, C. O., to Groton, S. D.  
Roberts, Thos. E., to Oak Park.  
Shipp, Farinda J., to Petersburg.  
Stanton, Lawrence M., to New York.  
Tillish, A., ——— to Cauley, Minn.

##### Changes to Chicago.

Crosby, Mary J., from Sioux City, Iowa, to Mary Thompson Hospital.

Norris, A. L., from Farmer City to 5002 Washington avenue.  
 Tracy, E. E., from Joliet to 103 State street.  
 Winslow, Thos. H., from San Luis Obispo, Cal., to Evanston.

#### Changes From Illinois.

Campbell, J. Y., Paxton to Rochester, Ind.  
 Chrisman, Lafayette to Ames, Iowa.  
 Graham, Little York to Petaluma, Cal.  
 Homey, Harlan, Rushville to Texas.  
 Kitzmiller, J. H., Taylorville to Oklahoma.  
 Menoher, J. A., Lawn Ridge to Winterset, Iowa.  
 Mills, H. M., Champaign to Tipton, Ind.  
 Skelly, J. J., Pekin to St. Louis, Mo.  
 Smith, R. L., Pawnee to McKingville, Ore.  
 Stoecks, W. A., Monmouth to Davenport.  
 Taylor, Walter S., Buffalo to Colorado.  
 Young, W. H., Quincy to Eldora.

#### Changes in Illinois.

Anthony, J. A., Chenoa to Peoria.  
 Axline, C. E., Woodburn to Oconee.  
 Adams, J. Q., Marengo to Union.  
 Akins, J. C., Secor to Polo.  
 Beadles, Chas. H., Bloomington to Oglesby.  
 Brown, J., Bernard to Cornell.  
 Burnham, A. F., Mason City to South Bartonville.  
 Cromwell, P. I., Beardstown to Effingham.  
 Calhoun, Topeka to Talula.  
 Crouch, E. L., Menard to Jacksonville.  
 Davidson, W. P., La Place to Sullivan.  
 Fisher, J. C., Petersburg to Decatur.  
 Gleeson, Ben. M., Springfield to Danville.  
 Hill, J. H., Springfield to LaSalle.  
 Hill, M. M., Springfield to Taylorville.  
 Kohlenbach, S., to Columbia.  
 Lemen, H. R., Philippine Islands to Upper Alton.  
 Morton, F. R., ——— to Taylorville.  
 McDonald, J. T., Taylorville to Mattoon.  
 Oakley, ——— to Moline.  
 Pennington, ——— to East Alton.  
 Ramsey, J., Wilson to Aledo.  
 Smith, S. D., Astoria to Rushville.  
 Short, W. T., Grove City to Stonington.  
 Taphorn, H. E., St. Louis to Alton.  
 Taylor, Harriet S., Springfield to La Grange.  
 Taylor, Geo. A., Hartsburg to Elkhart.  
 Utley, J. H., Springfield to Thayer.  
 Weir, L. J., West York to Marshall.  
 Zeller, Geo. A., Philippine Islands to Bartonville.  
 Zinn, J. W., Graymont to Flanagan.

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# The Illinois Medical Journal.

The Official Organ of The Illinois State Medical Society.

New Series, Vol. IV. }  
No. 8. }

Springfield, Ill., January, 1903.

{ SUBSCRIPTION  
\$3.00 A YEAR.

## THE PROGNOSIS AND TREATMENT OF SUPPURATIVE PLEURISY\*.

BY E. FLETCHER INGALS, M. D.

With an Analysis of 83 Cases Taken from  
My Own Records and Those of the Pres-  
byterian and Cook County Hospitals.

The prognosis of empyema has always been considered unfavorable and it becomes interesting to inquire how far this has been modified by the progress of surgery in recent years. Laennec writing in 1826 conveyed the impression that very few cases recovered, either with or without operation. Alfred L. Loomis<sup>1</sup> stated that the majority of empyemic children recover; while in adults although for a time there is improvement, it seems that phthisis is almost certain to develop sooner or later. He stated farther that statistics show that empyema of slow development where spontaneous openings occur, about 1 in 5 recover, while in those in whom artificial openings are established, the rate of mortality is considerably greater. He continues, "I am confident that the early introduction of a drainage tube into the pleural cavity in chronic cases would save many lives." Goodhart<sup>2</sup> in 1877 published interesting statistics of the results of different forms of treatment in 77 cases. In 15 of these the treatment was expectant, but only 11 or 13 per cent recovered. In the 83 records that I am considering of patients in whom artificial openings were made, 20 were in children under 15 years of age, of whom 18 were improved or recovered and 2 died; 63 were in older people, of whom 43 were improved or recovered and 20 died, leaving a total death rate after operative measures of 28 per cent.

I am unable to obtain accurate statistics of cases left entirely to nature or to medicinal treatment, but all of the authors at my

command agree that if left to themselves nearly all die. Dr. Samuel Wilks<sup>3</sup> reported 5 cases which had been left without operation, all of which terminated fatally. Martindale<sup>4</sup> reports fifteen cases left for a time to nature 2 recovered without rupture or incision, while 11 cases pointed and either broke or were incised; 9 of the 11 subsequently received the radical operation and recovered. Occasionally patients recover by absorption of the fluid and the encapsulation of the remaining pus where the effusion has been small; some recover by perforation of the lung and expectoration of the pus, some recover particularly of those cases due to the pneumococcus (25 per cent according to Jaccoud<sup>5</sup>, 40 per cent according to Netter<sup>6</sup>), by gradual filtration of the pus through the lung without serious lung involvement, and still others by perforation of the chest wall (empyema necessitatis).

Operative treatment changes the prognosis decidedly, the fatality being the exception in uncomplicated cases that are properly treated early. In 172 operative cases as reported by Koenig<sup>7</sup>, Cabot<sup>8</sup>, Eddison<sup>9</sup> and Runneberg<sup>10</sup>, 149 or 86 per cent made complete recoveries and only 12 or 7 per cent were known to be fatal. A few of the 172 had complications. Five had permanent fistulae and 3 disappeared before positive cure had resulted. Statistics show that in children under 3 years of age the mortality is about 50 per cent; over 3 years it is very small, ranging as low as 2 or 3 per cent. These results seem to have been exceptionally favorable, as Cheesman out of 12 cases at the Bellevue Hospital had 7 fatalities, 4 of which however were complicated by maladies already fatal in their tendencies. Netter reports a mortality of only 2 per cent in pneumonic cases, but 15 per cent in others. When due to the streptococcus pneumonia is usually more severe. Prudden<sup>11</sup> reporting a mortality of 5 out of 8 cases.

\*Presented to the Chicago Society of Internal Medicine, March 31st, and to the Illinois State Medical Society, May, 1902.

Four different operative procedures have been recommended with each of which there have been some recoveries and many failures. These are: Repeatedappings by small or large trocars or tapping by a large trocar and keeping the wound open by charpie as recommended by Hippocrates<sup>12</sup>; the introduction of Chassaignae's<sup>13</sup> or some other form of drainage tube; pleurotomy or free incision between the ribs and the excision of a portion of the rib with a free opening into the pleura and free drainage.

Hippocrates<sup>12</sup> also recommended an operation not very dissimilar to resection in which the rib was perforated; but with reference to this, Laennec<sup>14</sup> says, "I presume no one will ever think of reviving the perforation of the rib employed by the followers of Hippocrates, since it has many disadvantages peculiar to itself and no advantages over the common method." In the early days of operative procedures it was also recommended that the canula be left in the wound permanently and opened from time to time to allow drainage. Laennec states that puncture in the intercostal space by means of a trocar has been repeatedly employed by Morand and others, and that Recamier has several times performed the operation using a very small trocar. He further states that he had done the operation repeatedly himself but without ever having obtained any permanent benefit from it. But he says in favor of the operation that "It is attended by no inconvenience and gives always temporary relief, but only temporary."

Although inadequate for the majority of empyemas, aspiration is most useful in diagnosis and for giving temporary relief where indications do not call for a more radical operation immediately. Of 121 cases collected by Holt<sup>15</sup> 23 were cured by aspiration alone, 6 died, while 92 were further operated on, but they doubtless received temporary benefit from the aspiration—more than sufficient to counterbalance the delay. Aspiration as a preliminary measure was advocated by Henech and Rotch<sup>16</sup> and it has many adherents both in this country and in Europe. It gives the patient the chance of getting well without further operation, (20 per cent, Holt), and it may be wisest

when the empyema is of tubercular origin, since in many of these cases the effusion may not recur for a long time, or even resorption of the exudates may take place. The removal of the pus by means of a syringe was recommended by John Sculceus<sup>17</sup> in the early part of the 17th century, thus antedating by nearly 300 years the aspiration as now practiced which was introduced by Dieulafoy in 1869.

Notwithstanding Laennec's own unfortunate experience with tapping, occasional cases of recovery had been reported previous to the publication of his work.

From 1853 to 1864 a few cases of empyema cured by a single puncture were reported.

Several others are reported where a single puncture was made but the canula was left in the wound.

Among my own cases there were 4 cured by repeated aspirations. This result is much more likely to occur when the disease occurs in a child or when it follows pneumonia than in other conditions. This is accounted for by the fact that empyema in children is generally caused by the diplococcus pneumoniae (75 per cent, Whitman), and that the diplococcus is not very virulent.

Chassaignac recommended the introduction of a drainage tube through an opening made in the lower portion of the pleural sac and a counter opening cut down upon the point of the probe which had been passed from below to an intercostal space in the upper part of the chest, the probe being pushed out through the incision and a strong string attached which was fastened to the tube; as the probe was withdrawn the string and drainage tube was drawn in. This form of drainage, however, has not proved satisfactory. Gross<sup>24</sup> says: "When a spontaneous opening arises at the chest in empyema it will generally be found altogether inadequate \* \* \* both on account of its small size and its vicious site. A counter opening is sometimes made and a drainage tube recommended." Regarding the latter he says, "The use of the drainage tube has lately been recommended under such circumstances, but the treatment it seems to me, should not be encouraged and it is both harsh and danger-

ous." Potain<sup>25</sup> and Playfair<sup>26</sup> record several cases in which a drainage tube was introduced into the chest in such a way as to exclude air.

Goodhart's report shows that of 31 treated by the sub aqueous drainage as recommended by Potain, Playfair and Fagge, 13 or 41 per cent died; whereas, of 11 left to themselves in which there was spontaneous opening all recovered.

Puncture with a trocar through the canula of which a double tube was introduced and brought out with the end under water, was also recommended by Kussmaul's<sup>27</sup> in 1869; without knowledge of Kussmaul's recommendation I have used this method in most of my cases since 1872. For the past ten years I have employed a trocar so large that 2 drainage tubes each with a calibre of three-sixteenths of an inch could be passed through it. A tube of this size is so large that it obviates most of the objections which were properly urged against the tubes that were employed when this method was first introduced.

The advantages urged for the drainage tubes are that they enable us to secure free drainage and wash out the cavity thoroughly, and if introduced through a trocar in the proper manner, they enable us to exclude air for ten or twelve days during which time the lung will have expanded and the chest walls contracted to a great extent and adhesions will have taken place between the pleural surfaces so as to greatly diminish the size of the suppurative cavity.

If a free incision were made, the pleural cavity would be immediately filled by air, the lung would collapse and all of the benefits of the atmospheric pressure in dilating the lung and contracting the chest wall so that the healing could take place by adhesions of the two surfaces of the pleura to each other would be lost.

Loomis states that the chances are much greater for recovery after spontaneous opening, and the statistics of Goodhart<sup>2</sup> show that out of his 77 cases, the 11 that were left to nature all recovered, whereas under no other condition was the death rate less than 41 per cent. These facts appear to show that the nearer we can approach nature's methods,

the more likely we are to cure the disease; nevertheless, it can be urged against the drainage tube, introduced through a canula, that it does not enable us to remove large flakes of coagulated fibrin that may have collected in the lower part of the pleural sac. Notwithstanding this objection it has for years appeared to me that in practically all cases of only a few weeks duration, but more especially in young children, the operation done in this way is much more successful than free incision between the ribs, or exsection of one or more of the ribs.

Of my own cases, all of which were operated on by introducing a drainage tube through a trocar, 6 were of less than 4 weeks' duration and all of these recovered; 14 were of from 2 months to 2 years' duration and of these only 9 recovered. In other words 100 per cent recovered in early cases and only 64 per cent in those of longer duration. In all of these cases I have seen only 2 in which the pressure of the ribs interfered with the calibre of the tubes; in one of these exsection of a rib was done and recovery finally followed and in the other, death resulted from sepsis about 2 weeks after the operation.

According to Goodhart's statistics, of 12 cases operated on by free incision, 6 or 50 per cent died, but of the 7 cases operated upon in this way, in the records that I have collected, 5 recovered and only 2 or 29 per cent died.

Wilson Fox<sup>23</sup> recommends that a valve-like opening be made through the skin and the knife not allowed to penetrate the thoracic cavity, thus preserving nature's method. Under other conditions, it would probably be safer to make an opening at the lower part of the pleural cavity sufficiently large for the expulsion of the coagulated fibrin, but I fear this would seldom be attained by a simple pleurotomy, therefore, where it is necessary to remove coagulated fibrin, exsection of one or two ribs is desirable in order to make an opening sufficiently large for the introduction of the finger to scrape out the fibrinous deposit.

It was at one time supposed that repeated irrigation of the pleural cavity was of special value as it proved to be in some cases.



Cabot<sup>28</sup> reported 4 of his own and 10 cases collected from the literature, where aspiration was followed by syringing or irrigating the cavity with a carbolized solution. All the cases recovered.

The duration of the trouble after operation was from nine days to three and a half months. Later statistics, however, appear to show that irrigation tends to prolong the suppurative process. Runeberg<sup>10</sup> reports show that early, when irrigation was used, there were only 30 per cent of cures and an average duration of 101 days, while subsequently by a single lavage the cures increased to 70 per cent with an average duration of only 84 days.

Of the 83 cases that I am considering 41 were operated upon by exsection of a portion of one or more ribs and of these only 12 or 30 per cent recovered, while 70 per cent died.

Exsection of the rib is easily performed and wherever the intercostal spaces are greatly narrowed by retraction of the chest, as when there has been perforation of the lung and the pus has been continually escaping for a long time, this operation is the only one to be recommended. In acute cases where retraction has not taken place, I believe that the introduction of the double drainage tube through a canula and the exclusion of air for several days after the operation very considerably improves the patient's chances for life, for although exsection of a rib is easy the danger of secondary infection especially through the cut ends of the rib is considerable and the operation is much more formidable than that by the trocar.

Being fully convinced of the advantages of the operation by the trocar, I wish to urge it in all suitable cases, which, by the way, comprises nearly all of the empyemas in children and the great majority of cases in adults in whom the disease is not of more than 2 or 3 months' duration. In these 83 cases (which were taken in order without any selection) of those operated upon by the method I recommend, 70 per cent recovered, while of those in whom exsection of a rib was done, only 30 per cent recovered.

The directions for this operation and the subsequent treatment as I have elsewhere

written are as follows: The operation which I have employed with much satisfaction for many years is well adapted to all cases in which marked retraction of the chest has not occurred. It is performed by means of a broad, flat trocar sufficiently large to admit the passage of two drainage tubes at once. If an anaesthetic is thought necessary, nitrous oxide gas may be advantageously used, as its effects are quickly over; but it will usually be sufficient to inject deep into the intercostal tissues, as well as just beneath the skin, a few drops of a 4 per cent solution of cocaine such as recommended for local anaesthesia in the nose. *R.* Atropin gr. one-tenth, Strophanthin gr. one-fifth, Ol Caryophili m iii, Acid Carbolie gr. x, Cocaine Hydrochlorat gr. xx, Aq. dist ad oz i. *M. S.* Local anaesthetic.

The skin having been made thoroughly clean, it is punctured by a small scalpel, which makes an incision about a quarter of an inch in length, the point of the trocar is entered into this incision, and then the instrument is plunged boldly into the chest. As soon as the stilette is withdrawn, the thumb of the operator is placed over the mouth of the canula to prevent the escape of pus; and then the tubes, which have been previously prepared, are slipped quickly through the canula to the required depth, the canula is withdrawn and the tubes are left in the chest. A bit of sheet rubber about three inches square, with two small openings near the centre and close together, is now slipped over the tubes and down to the chest wall. Next, a section of the same tubing about half an inch in length, through which have been tied loops of stout thread each about an inch in length, is passed down over the drainage tube to the chest wall. Both tubes are treated alike, and through the loops are passed long strips of adhesive plaster, by which they are bound firmly to the chest wall.

The drainage tube is now perfectly under the control of the operator; it cannot possibly slide in to the chest, and the adhesive straps keep it from being forced out a few days later when the tissues about it have retracted. The section of sheet rubber placed next to the chest wall acts as a valve, pre-

venting air from entering the chest at least for the first eight or ten days; that is, until the retraction of the tissues occurs about the tubing. A roller bandage is applied over the whole, the drainage tubes being allowed to protrude through it.

In preparing the drainage tube, I take a piece of pure gum tubing, about two feet in length and three-sixteenths of an inch in calibre, and cut it half across near the middle; it is then folded upon itself, one of the tubes is perforated in several places, extending about three inches from this cut end, the other in a couple of places extending about one inch. About an inch and a half from this end the two tubes are stitched together at a single point with strong silk. The stitch is made through one of the perforations and knotted within the tube; then, if by any means it becomes loose, it is likely to be washed out. When folded upon itself and fastened in this way, one of the tubes is cut about half an inch shorter than the other, so that the operator may know subsequently which tube is perforated the greater distance from the end. About six inches from the end of the tube which is passed into the chest, a bit of thread is tied closely about it as a mark, in order that during the operation the surgeon may know how far it has been passed through the canula. Finally, the outer ends of the tubes are tied tightly or closed by clamp forceps and the whole is made aseptic by soaking in a strongly carbolyzed solution. By thus closing the ends of the tubes, we are enabled to slip them through the canula, withdraw the latter, and complete the operation even when the chest is much distended, without the escape of more than one or two ounces of pus. After the dressings are completed, the drainage tubes may be bent upon themselves or clamped to seal them hermetically, while the ends are opened and connected by short glass tubes to longer rubber tubes, through which the cavity may be washed or drained according to indications. It has been my custom to wash out the pleural sac immediately with an antiseptic solution and to have the washing repeated afterward once or twice daily for a couple of weeks, and subsequently less frequently until the sac is

obliterated, but as shown by the reports of Runeberg, it is probable that excepting when there is temperature it would be better not to irrigate. If washing is decided on, the solution should be used at a temperature of 101° F. Between the washings the ends of the tubes may be bent upon themselves and tied, or they may be left hanging in a bottle containing some antiseptic solution, as thought best. When the patient is able to walk about, I usually allow drainage to go on constantly into a bottle which the patient carries in his pocket.

In cases of empyema which have lasted for a long time, it is sometimes important that about the fifth or sixth week after the operation the physician should ascertain whether the cavity is decreasing in size; this can easily be done by measuring the quantity of fluid required to fill it. Usually the pleural sac rapidly contracts until it will not hold more than four or five ounces; but after this, especially in adult cases of long standing, the contraction may be very slow. It then appears desirable to use stimulating injections, such as aqueous solutions of zinc sulphate gr. ii to iv ad 1 oz.; iron sulphate double this strength; compound solution of iodine, half dr. to a dr. ad 1 oz.; or copper sulphate, gr. v to gr. xx ad oz. 1. If iodine is used it will attack the drainage tubes so that they must be renewed every two or three days. Protargol 4-6 per cent in water has a marvelous effect in checking suppuration, and I believe it would be most valuable in these cases. A solution of the oil of cloves in water ( $\frac{3}{4}$  of one per cent) or an emulsion of iodoform may be used for the same purpose. When the cavity has so far contracted as to hold not more than two or three drachms, the drainage tubes may be withdrawn about half an inch, left in this position for two or three days, then withdrawn as much farther, and so on until they are out of the pleural cavity, when the external wound readily closes.

For years I have taught that this was the best operation for nearly all recent cases; but when I read the sanguine statements of Whitney<sup>30</sup>, who says, "Left to itself, it is an unusually fatal affection; submitted to the benign influence of modern surgery,

there are, in general, few conditions whose outcome is so satisfactory," and when I saw even more confident statements made by others, I suspected that I had made a mistake. This analysis was undertaken to aid in determining the relative value of different forms of treatment. The statistics have been gathered by N. P. Colwell, who examined my own records and the hospital records for two or three years. He did not carry the examination of the latter as far as we had intended because these records are not indexed and after spending several weeks upon the work, we found that time would not permit a further search. Until the article was practically completed and Dr. Colwell had inserted the figures, I had no idea what the result would be. I am surprised that the results of exsection are not better, but gratified that an operation which any of you may perform without the aid of a surgeon and that is much less formidable to the patients is shown in such a favorable light. If you will perform this operation early in the cases of empyema caused by the pneumococcus you may expect about 95 to 98 per cent of recoveries, and in all other cases where the side is not retracted, you may anticipate as good results as from any other operation. This operation does not require general anaesthesia and it is no bar to a subsequent exsection. If after a few months a cavity remains that cannot collapse because of the induration of the lung and the rigidity of the chest walls, in favorable cases portions of two or more ribs should be removed to allow the walls to come together so that healing may occur. I believe that any radical operation for empyema should be preceded by aspiration; and where the patients condition will permit, the aspiration should be repeated every four or five days until the cavity is emptied; then after allowing a short time for reaccumulation of pus the radical operation should be done. In this way we may expect the most rapid and the most successful results.

1. Alfred L. Loomis, Practical Medicine, 1890.
2. Goodhart, Guy's Hosp. Rep., 1877.
3. Samuel Wilks, Brit. Medical Journal, 1879.

4. Martindale, Am. Jour. of Med. Science, 1881.
5. Jaccoud, Twentieth Century Practice of Medicine, Vol. VII, 1896.
6. Netter, Traite de Medicine, 1893.
7. Koenig, Berkiner klin. Woch., 1891.
8. Cabot, Twentieth Century Pract. of Med., Vol. VII, 1896.
9. Eddison, Twentieth Century Pract. of Med., Vol. VII, 1896.
10. Runeberg, Zeitsch, fuer klin Med., 1892.
11. Prudden, New York Medical Journal, 1893.
12. Hippocrates, Lacnnee, *ibid.*
13. Chassaignac Bull. Acad. Med., 1872.
14. Laennec, Diseases of the Chest, etc., by J. Forbes, 1838.
15. Holt, Archives of Pediatrics, 1892.
16. Rotch, Pediatrics, 1895.
17. Sculceus, Lacnnee *ibid.*
18. W. W. Gerhard, The Chest, Fourth Ed., 1860.
19. Aran, Bull. Therap., 1853.
20. Hamilton Roe, Lancet II, 62, 1860.
21. Oeri, Die Thoracentise, p. 168.
22. Woillez, Bull. Med. Hop., 1864.
23. Wilson Fox, Diseases of Lungs and Pleura, 1892.
24. Gross, System of Surgery, 1866.
25. Potain, Bull. Therap., 1869.
26. Playfair, Trans. Obs. Soc., 1872.
27. Kussmaul, Berlin klin. Woch., 1869.
28. Cabot, N. Y. Med. Jour., Vol. XXXII, 1880.
29. Ingals' Diseases of the Chest, Throat and Nose, 1900.
30. H. B. Whitney, Twentieth Century Pract. of Med., Vol. VII, 1896.

#### Discussion.

N. S. Davis, Jr., of Chicago: Mr. Chairman—There is but little to add to what Dr. Ingals so ably said in regard to this matter, but I agree with him very fully in that the operation of aspiration, and then the operation of puncture, by trocar, and the introduction of the drainage tube is one that every physician can do with perfect ease and should do himself rather than employ a surgeon to do them for him. It seems to me most important to make a correct and early diagnosis in these cases. By means of microscopic examination, you can frequently determine the kind of infection, whether diplococcus, streptococcus or some other germs, such as the pneumococcus, which can very frequently be found almost in pure cul-



ture. By that means not only the kind of infection can be determined, but also the best method of treatment.

In cases of mild infection, drastic measures need not be instituted. Emptying the cavity by aspiration and drainage, even through a tube of small caliber, is all that is required. In other cases we have to do with a more virulent disease, one that requires heroic measures, such as resection of the ribs, etc. It is important to make a thorough diagnosis in order that the treatment may be accurate.

**Jacob Frank**, of Chicago: I have had some little experience in the operative treatment of empyema, and used the method described by Dr. Ingals a great many years ago. I used the knife, plunging it in between the ribs, and also withdrew the fluid through an aspirator. There are many cases in which the pus does not remain in the pleura alone, or in others there are many pockets. Again, there is the danger of caries or necrosis of the ribs. Incision and resection of the rib is a great deal less painful than the disease itself. It makes quite a difference in these cases which are operated on whether they are due to the pneumococcus or whether it is a tubercular infection. I do not know whether Dr. Ingals made a distinction between these in his recoveries. Cases will recover repeatedly from a pneumococcus infection, but when the process is tubercular, it is quite a different matter.

If these empyema cases were operated on early, and I think Dr. Ingals advocated that, there would be far less work for the general surgeon in the way of doing plastic operations, because these old neglected cases where the pleura is very thick always require a plastic operation later on. I think that a rib or two carefully resected at the most dependent part, the periosteum carefully stripped off from the bone, so as to injure as little tissue as possible, will always produce a much more rapid recovery. Besides, there is less necessity for plastic work.

I think the doctor will agree with me that it is bad policy to leave in the drainage tube. I use a rubber catheter with a little collar on one end. It is very safe. I first place a sound into the cavity, then follow it up with the catheter, introducing it into the pleura and it is retained there without any trouble whatever. It will not slip out, nor can it be drawn in by the respiratory efforts. It is also very comfortable. In my work on empyema I always had more trouble in keeping in the tube than with any other portion of the operation.

As to through and through drainage, this can be made from before backwards, or from above down. If the drain does not drain perfectly, I think it is proper to explore the cavity with a sound and usually you will find that there is a good reason for the imperfect drainage.

I also wish to call attention to the necessity of collecting the fluid in a bottle that is placed in a suitable pocket. I have in mind now a case that I operated on by puncture about nine years ago. I introduced a rubber tube, a catheter, from the end of which ran a small hose which emptied into a bottle which the man car-

ried in his inside vest pocket. This enabled him to walk around during the entire treatment. The man is alive today, and in perfect health. I have never yet seen a case of empyema get well after repeated aspirations. It is a waste of time. When the diagnosis is made of pus in the pleural cavity, I think it ought to be operated and drained at once.

**Dr. ————**, of ————: I had a little experience recently in a case of this kind. I discovered that by introducing the trocar with a fairly large canula, you can withdraw the canula and introduce through the same opening a rubber tube, especially one of the catheter kind. In my practice in the country it is very difficult to obtain surgical aid, and we have to resort to a great many expedients so as to do the best we can for our patients, and I have found that by first using a trocar and then introducing a good-sized tube, every indication is met. In the case I have in mind I washed out the cavity with sterilized water, running in a large amount until the water came away perfectly clear and free from pus. The patient got well in a reasonable time.

**L. C. Taylor**, of Springfield: I had under my observation quite recently a case in which the diagnosis of empyema was made some three months before I saw him. I made an examination and found that every sign pointed to an exudate in the pleural cavity. I aspirated a number of times, but failed to get any pus. I have had the same experience in several other instances. The following day I was hurriedly telephoned that my patient had expectorated about a gallon of pus during the night. A sample was sent to my office, and I found it to be pure pus. A microscopic examination showed streptococci in abundance. Tubercle bacilli were absent. The interesting feature in this case was the fever which immediately went down after the perforation of the bronchus, following which came this large amount of pus, which, of course, was not a gallon. I think a diagnosis of tuberculosis had been made before. The temperature remained normal for three or four weeks, although occasionally the fever went up, and with the same result as before, except that a smaller amount of pus was discharged. I supposed that the pus would develop during the three weeks, and then discharge through the perforated bronchus.

What is the treatment in a case of this kind when we can exclude tuberculosis? I have had no difficulty whatever in retaining a tube of any size at all by simply introducing an ordinary safety-pin through the tube, and wrapping around both a small piece of gauze. It answered every purpose, and with this method I have never yet had a single tube slip out.

**Dr. Ingals** (closing the discussion): It was suggested that the use of the trocar is painful. It is not painful. I introduce first two or three minims of a four per cent solution of cocaine, injecting it straight into the point where I wish to make the opening. In using the large trocar, I employ a five-eighths inch broad and one-fourth inch thick, I have to make an opening about one-quarter inch long with a knife, as you cannot draw so large a trocar through.

The point is introduced and plunged in. There is no pain, at least not more than a fraction of a second in duration, which does not count for anything. The use of the drainage tube, according to my experience, has one objection, and that is that when the cavity is closing the drainage tube usually comes out. I usually employ a very common procedure for keeping the tube in place. I cut a short section of drainage tube, one-half inch in length, and slip it down over the tube, close to the chest wall, and through the loops I place strips of plaster eighteen inches long, so that the tube can neither go out nor in, but will remain in accurate position until the cavity begins to close up. When the tube is gradually forced out, then it must be shortened.

In regard to drainage into a bottle, my experience is similar to that of Dr. Frank. I have found that men find it especially easy to carry a flat whiskey flask in the hip pocket into which the tube empties.

Dr. Frank's suggestion that it is foolish to waste time in aspiration is quite correct, if you are attempting to cure the case by aspiration. My idea is not to hope to cure by that method, but simply to continue to aspirate until you have emptied the cavity at least once. If the sepsis is marked, and if there is high temperature, wait three or four days for the pus to accumulate, and then use the trocar. I had a man come to me once in whom I found a cavity full of pus. I withdrew gallons of pus from his chest, and aspirated seven times before I could empty the cavity. I had hoped that the atmosphere pressure would crowd out the lung and bring it in contact with the chest wall, thus favoring the formation of adhesions between these two surfaces. After the seventh aspiration I gained the desired result.

The largest tube I have been able to introduce through this canula is three-sixteenths of an inch in diameter. I presume that by crowding in the tube, as suggested by Dr. Frank, we might probably get in a still larger tube, but this is the largest I have ever used. The treatment of cases in which there has been a perforation of a bronchus will very likely demand exsection of the ribs and very free and thorough drainage. Nearly always, where perforation has occurred, the chest wall is greatly contracted, until the ribs come close together and you do not have enough room for a large tube. Then do your exsection. It would seem to me, judging from the history the gentleman gave, that he was probably not dealing with an empyema, but with an abscess of the lung. If he had explored four or five times, he would have been very likely to strike pus in the pleural sac, but if pus is in the lung, it is possible that it will be missed. In cases of pus in the lung, drainage is, of course, very important.

#### CHANGE OF DATE.

Do not forget that the date of holding the annual meeting has been changed to April 29-30, May 1-2, 1903

## TECHNIQUE, INDICATIONS AND LIMITATIONS OF VAGINAL SECTION AND DRAINAGE FOR PELVIC DISEASE.\*

BY THOMAS J. WATKINS, M. D., CHICAGO.

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This paper will not consider drainage as a part of the toilette of an abdominal operation. It will consider vaginal section and drainage as the remedy for selected cases *only* of pelvic disease.

Vaginal section and drainage as now practiced is a comparatively new operation. Pelvic abscesses were aspirated, punctured and incised long ago, but the descriptions of the operations which were done before the pathology of pelvic diseases was well known, before the time of aseptic surgery was practiced and when surgeons feared to make free vaginal incisions, now impress one as fiction.

*Technique.* The preparatory treatment should be as thorough as for an abdominal section, for conditions may arise that will indicate or necessitate an abdominal section. On account of the possibility of an extensive operation the patient should if practicable, be cared for in a hospital. After the usual aseptic preparation the patient is anesthetized, placed in the lithotomy position and a perineal retractor inserted.

The uterus is curetted, if indicated by the presence of hemorrhage or a purulent discharge. A thorough conjoined examination is made to determine if possible more accurately the pathological condition than could be found before the anesthetic was given, and to determine the point in the vagina to be incised that will give the most ready access to the diseased tissue and the most perfect drainage. This point will be, almost invariably, in the posterior vaginal fornix because in most cases of intra pelvic disease the site of the trouble is located posteriorly to the uterus and broad ligaments, in rare case to be mentioned later, the incision should be in front or to the side of the cervix.

*Incision.* An incision is made in the

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.



posterior vaginal fornix by grasping the posterior lip of the cervix with a volsellum forceps. The cervix is drawn downward and forward and a free transverse incision is made through the upper portion of the posterior vaginal wall. If more room is required the wound is enlarged by making a longitudinal incision downward through the posterior vaginal wall.

In case of a pelvic abscess the finger is forced through the peritoneum into the abscess, care being taken not to exert pressure over the abdomen for fear of causing rupture of the abscess. If the abscess is not in close proximity to the vagina care should be taken not to injure the rectum or an adherent loop of intestine. This may be accomplished by dissecting with the finger close to the posterior wall of the uterus until it comes in contact with the abscess sac. It is often a simple procedure to open and drain a pelvic abscess, but it may require more skill to determine the amount and character of the pathological process, to avoid injury of important structures, and to evacuate all of the pus than to perform an ordinary abdominal section.

In case of hematocele, from rupture of an ectopic pregnancy, the peritoneum may be incised, or it may be punctured with the finger or a blunt pointed scissors or forceps. In case of a broad ligament cyst the sac may be punctured without opening the peritoneal cavity. The opening is now thoroughly stretched with the two index fingers. The cavity is thoroughly sponged dry and a conjoined examination is made with one or two fingers in the wound and with one hand over the abdomen. In suppurating cases one or more additional abscesses will in this way, at times, be found, which should be opened, sponged dry and drained. Unsatisfactory results have occurred from a failure to open and drain all the pockets of the pus. There is always danger of opening the peritoneal cavity in septic cases, but little harm usually results then if the pus is thoroughly removed with gauze sponges and the abscess cavity carefully drained. In non-septic cases there is but little objection to opening the peritoneal cavity, and in fact it should be opened if doubt exists as to the exact condition of

the pelvic organs.

Irrigation should be used, I believe, in exceptional cases only, if at all, as cleansing can usually be more thoroughly accomplished by the free use of gauze, and by the use of irrigation there is always danger of disseminating infection. In cases of pelvic hematocele care should be taken to remove most of the blood clots for if left they will suppurate, complicate and prolong the convalescence.

I desire to condemn the use of exploratory needles and aspirators as useless, cowardly, unintelligent and dangerous procedures. In some purulent cases, the pus may not be found on account of the presence of a large amount of exudate or of very thick pus. In cases of hematocele the needle may become obstructed by a blood clot and thus fail to show the character of the disease. Consequently the use of the needle may not only fail to determine, but it may be misleading in the diagnosis; it may extend the infection and it may injure a bowel, a ureter or a uterine artery. The use of an aspirator can be of almost no permanent good as it does not establish any drainage.

*Drainage.* I formerly almost invariably employed tube drainage, but now usually use gauze drainage as experience has taught that the use of gauze drainage is usually attended by less temperature, less pain, requires less care than when rubber tubes are used, and a more rapid convalescence follows. Tube drainage always tends to increase the amount of suppuration. The drain consists of a narrow continuous strip of gauze. The cavity to be drained is exposed by two long retractors and is moderately filled with the gauze.

If the progress of the case is satisfactory none of the gauze is removed until the end of forty-eight hours when about one-fifth of it is removed and this is repeated each twenty-four hours until it is all removed, when the cavity will be nearly obliterated. In a few pus cases it has been necessary by the presence of unfavorable symptoms to remove the gauze earlier and to resort to frequent antiseptic irrigations with or without the use of rubber drainage tubes.

In exceptional purulent cases the abscess



is located in front of the uterus and is best treated through an incision in the anterior vaginal fornix. I have had two such cases. In these cases, however, it is advisable at times to also make a free incision posteriorly to the cervix so as to drain the most dependent portion of the abdominal cavity. In one case which I opened and drained through the anterior vaginal fornix, an incision through the posterior vaginal fornix showed that some of the pus had escaped into Douglas cul-de-sac.

*Indications for Vaginal Section and Drainage for Pelvic Abscess.* 1. All acute cases in which a large abscess is in close proximity to the vaginal canal.

2. In all other acute cases in which it is not possible to open the abscess extraperitoneally through an abdominal incision and in which the symptoms indicate great danger in delaying operation until the suppuration extends to the floor of the pelvis or to the abdominal wall or until the case becomes afebrile.

There are a few exceptional cases where it may be advisable to do a radical operation during the febrile stage. I believe the danger at this time of radical operations (especially abdominal) sections cannot be too much emphasized. The danger of radical operations during the febrile stage is usually infinitely greater than the danger of waiting for the afebrile stage plus the danger of operation at the latter period.

3. All circumscribed, large chronic abscesses, with small amount of inflammatory exudate, which can be easily opened through a vaginal incision.

The number of these cases will be small and will not include gonorrheal and tubercular abscesses as they are always attended by a large amount of inflammatory exudate. Acute is intended to include all febrile, while chronic includes all afebrile cases. From a bacteriological standpoint, acute might be classed as septic and chronic as non-septic cases.

The indications should be governed somewhat by the nature of the infection. Puerperal cases are usually the best subjects for vaginal section and drainage, as the

amount of inflammatory exudate in these cases is comparatively small and tends to entirely disappear by absorption.

Gonorrheal cases are bad subjects for incision and drainage as they are usually attended by a large amount of exudate and the gonococci are liable to remain latent and to cause trouble after an indefinite time. Gonorrheal cases are especially dangerous to operate during the acute stage on account of the great liability of septicemia and operations in these cases can usually be postponed with safety until the afebrile stage, when the operation should be a radical one. In my experience it is often impossible to determine before commencing the operation whether it should consist in making a vaginal section and drainage or in doing a more radical operation. In such cases I am inclined to make a vaginal section for exploration and then determine what seems to be the most advisable procedure to pursue. An extremist might say that it is impossible for a suppurating Fallopian tube or ovary to recover after incision and drainage. If this be true then the same is true of the connective tissue adjacent to the suppurating tube or ovary which has been subjected to the same infection and to the same kind of inflammatory exudate. The same might be said of abscess of the breast and other abscesses.

The conclusion is that only a small percentage of cases of pelvic suppuration should be operated during the febrile period and when operation is required at that time it should usually consist in vaginal section and drainage. In doubtful acute cases the tendency of the disease to improve or to get worse will often be of aid in determining the best method to pursue.

A review about one year ago of my cases at St. Luke's and Wesley Hospitals showed that in six hundred and eight (608) cases of pelvic disease forty-one (41) of them were treated for pelvic abscess by vaginal section and drainage. One died. In this case the operation was performed ten days after an abortion and the patient had a pelvic abscess with general suppurative peritonitis.

Four of the cases required subsequent

operations. In one of these an abscess occurred three years later without any apparent cause and was removed by abdominal section. Another developed an abscess two and one-half years later as the result of a gonorrheal infection and was treated by vaginal section and drainage. This shows that about ten per cent required subsequent operation.

*Pelvic Hematocele.* This disease is probably always the result of an ectopic pregnancy. If suppuration has not occurred the use of gauze is much preferable to tube drainage on account of the lessened danger of infection.

I believe that in all cases of hematocele a free vaginal incision should be made, for the purpose of evacuating the blood and to determine whether the operation will be completed by drainage or by removal of the affected tube. If a distinct mass is found in the upper wall of the hematocele or if much hemorrhage occurs the tube should be immediately removed, usually by abdominal section, otherwise a cure may be expected to result from the simple use of gauze drainage. In two cases I have opened and scraped out the affected tube with a finger without causing any appreciable bleeding.

The objection given to this treatment has been the danger of hemorrhage. If care is used not to disturb the wall of the hematocele except at the point of puncture there can be no danger of serious hemorrhage. The possibility of the pregnancy continuing in the tube always suggests itself. Usually the pregnancy is interrupted when the hematocele occurs as the fetus then usually escapes from the tube and loses its blood supply. When the pregnancy has not been interrupted the tube will be detected as a distinct mass, which will indicate its removal.

Vaginal section and drainage should usually be the treatment when the hematocele has been infected. The adhesions which always accompany hematocele often make a radical operation exceedingly difficult. In one of my early cases such firm adhesions were encountered on abdominal section that it seemed impossible to remove the affected tube without serious injury to the intestines

and the operation was completed by making vaginal section and drainage.

In about twenty cases of hematocele which were incised through the vagina the pregnant tube was immediately removed by abdominal section in three cases. In these three cases a distinct mass was found in the upper part of the wall after the blood was evacuated. In one case the tube was removed by abdominal section one week later on account of hemorrhage. In this case, however, the indications were to remove the tube during the primary operation, but the patient would not consent to an abdominal section and the danger of hemorrhage seemed too great to attempt removal through the vaginal incision. In one case the tube was removed two years later as it was the seat of an inflammatory mass which was causing pain. In one recent case a slight arterial hemorrhage continued for about one week when it stopped without any special attention.

*Broad Ligament Cysts.* These cysts can be opened and drained without entering the peritoneal cavity. If, however, any disease of the uterine appendages is suspected the incision should extend into the peritoneal cavity for the purpose of exploration. The gauze drain is managed as already described. The cyst is obliterated principally by collapse of its walls and they become agglutinated from the irritation produced by the gauze. I believe this is the treatment for all cases of simple nonpedunculated broad ligament cysts.

The usual method of removal of these cysts by enucleation through an abdominal incision is a very dangerous procedure for a comparatively simple pathological condition. The dangers are greater and postoperative sequelae are more numerous than for ovarian cysts on account of the difficulty of the operation, the increased danger to hemorrhage and the large amount of denuded surface that results. With the vaginal operation the danger to life should be but little more than the danger of the anesthetic. The technique is simple, but little pain results and the patient should be up and about after one week. There is no more danger

of refilling of the sac than there is of recurrence of a hydrocele after it has been freely incised and thoroughly drained.

After removal of a broad ligament cyst by abdominal section an exudate frequently occurs at the site of operation and lasts for a long time protracting convalescence and causing distress. This does not occur after vaginal section and drainage.

The gravity of the abdominal section for a broad ligament cyst is best illustrated by mentioning the fact that in some of the cases it is necessary to remove the uterus in order to complete the operation.

Thick walled broad ligament cysts which originate in the paroophoron are not applicable for this operation and should be enucleated on account of the danger of malignancy and refilling of the cyst.

The greatest difficulty arises in making the diagnosis. It is beyond the scope of this paper to enter into the differential diagnosis. In doubtful cases I believe in making a vaginal section for exploration. In case a simple nonpedunculated broad ligament cyst has not been detected until after an abdominal section has been made I believe it is usually advisable to abandon the abdominal operation and to open the drain through a vaginal incision. The slight tendency of these cysts to refill is illustrated by the fact that they often do not refill after they have been accidentally ruptured, aspirated or a portion of the sac excised. None of them have refilled to my knowledge after vaginal section and drainage.

*Puerperal Infection.* Vaginal section and drainage is often of great value in cases of puerperal infection for exploration and to establish drainage. It is difficult to clearly define the indications for this treatment as the cases vary so much on account of the variety and virulency of the infection. Vaginal section is seldom indicated in the very early stage of the disease and should not be employed until one determines the condition of the cavity of the uterus. If some of the products of conception are found in the uterine cavity it is seldom indicated until after the progress of the case is watched subsequent to thorough evacuation of the uterus. A vaginal section is indicated for

exploration in early cases with signs of general peritonitis when the progress of the case is unfavorable. If an ovarian abscess or pyosalpinx is found on section the pus should be thoroughly evacuated and drainage established. This treatment will give better results than a radical operation because it is accompanied by much less traumatism and there remains less surface for absorption. Hysterectomy in these cases has almost universally been disappointing in results.

An exception may be made in some cases of gonorrheal infection. My only successful hysterectomy in this class of cases was a gonorrheal one where suppuration had occurred in the uterine wall, the Fallopian tubes and the ovaries. Even in cases when the puerperal uterus has been perforated I believe the free use of drainage will give better results than hysterectomy. I have done vaginal hysterectomy three times during the puerperium where the uterus had been perforated during curettage with fatal result in each case. From a subsequent study of these cases it would seem that the free use of gauze drainage would have increased the chances of recovery.

Vaginal section and drainage is indicated in all cases where there is an inflammatory mass or a suspicion of one posterior or to the side of the uterus where the progress of the case is unfavorable after careful attention has been given to the uterine cavity. The operation when carefully done can produce little or no harm, will determine the exact condition of the organs and when intra pelvic suppuration is found it will give the patient the best possible chance for recovery. The tendency to complete resolution by absorption of non-suppurating puerperal inflammatory masses is well known. The resolution by absorption will be equally complete in puerperal cases that recover after drainage of suppurating tissue. Vaginal section should of course not be employed in cases when the abscess is distant from the vagina and can be opened extra peritoneally by an abdominal incision.

In two cases where I have made vaginal section and drainage during the puerperium pus was found in the general peritoneal cavity and both cases recovered. In one case



the uterus was found perforated and recovery followed the free use of drainage. This patient subsequently became pregnant and had a normal gestation and labor. In one case where a double pyosalpinx was encountered, free evacuation of the pus and the use of gauze drainage resulted in recovery. In a number of the operations a general suppurative peritonitis has been encountered and death has resulted as will usually occur with any known treatment.

Vaginal section in cases of puerperal infection is not indicated in the absence of signs of pelvic or general peritonitis and especially when the progress of the case tends to a continued improvement.

#### Discussion.

**Charles S. Bacon**, of Chicago: Mr. President—When I consented to open the discussion on this paper, I did it with a feeling that I was hardly the proper man to discuss a paper on this subject by Dr. Watkins, because he is recognized as an expert in vaginal work, and I think we got a great deal of good from hearing the results of such work. Of course, the opinions held by Dr. Watkins on this subject are known to you, and are contradictory to those held by a great many operators. If our esteemed colleague from Philadelphia, Dr. Joseph Price, were here, we should have an interesting discussion on this subject, because of the opposition he would make to this paper. But the results are what tell, and if Dr. Watkins gets the results, it proves the value of the operation, and I have no doubt at all that if the majority of operators followed the indications that Dr. Watkins lays down, the vaginal would be of more value than the abdominal operation.

Speaking about the technique, the only point I make would be to express dissatisfaction as to the use of the term drainage as compared with packing by gauze. There is no question that gauze packing is preferable to the use of a drainage tube, but the object of the packing is not at all that of drainage. The use of gauze is hardly drainage; it is a packing, and has for its object the exerting of an influence by pressure. It seems to me, that the common use of the term drainage, when applied to gauze, is a little objectionable.

The chief interest of the paper lies in the indications for treatment, and perhaps the chief indication was not fully elaborated by Dr. Watkins on account of his failure to read the last report of his paper where he speaks more particularly of post-mortem conditions, and there is the chief indication. But without speaking of that further, we come to the next very important consideration, and that is the use of drainage in extra-uterine pregnancy or conditions of hematocele, which are the result of extra-uterine pregnancy. It is rather surprising to hear that the Doctor doubts such an extensive indication. The use of drainage in in-

fect cases of hematocele is the treatment, and by infected cases one should include all those cases where the hematocele is not changed into an abscess, but where there is not a true infection, perhaps, but an intoxication. We often find a condition in which there is fever, but we do not find abscess.

**Elizabeth H. Dunn**, of Chicago: I was very glad to hear Dr. Watkins' paper, and I concur in his method of treatment. I consider it quite conservative, and think that if 90 per cent. of the cases recover by this method, the radical operation is not frequently indicated.

The only point on which I disagree with the essayist would be his objection to the use of the rubber tube where extensive drainage is necessary. I think I would use a tube, also gauze, removing the gauze in a few days, perhaps the third or fourth day, permitting the tube to remain perhaps seven or eight days.

**Charles B. Reed**, of Chicago: I would like to say a few words in reference to this method of incision and drainage in the puerperium, especially in the infected cases. I have in mind a case which I recently had the opportunity of seeing post-mortem. The woman was delivered in our own hospital by a senior interne with rubber gloves, and under the most radical aseptic precautions, yet she developed on the second day a temperature. The temperature and the general condition passed through the phases of sepsis. The woman died on the eighteenth day. Delivery was normal, but extremely painful. The facilities for taking septic cases in the Chicago Lying-In Hospital not being satisfactory, the woman was removed to Wesleyan Hospital. Here the case was observed by several excellent men, one of whom made the ordinary examination, there being only one examination made. She died of general peritonitis. Post-mortem examination showed a pyosalpinx as large as an orange in the cul de sac. The abdomen was filled with fluid, and in the vicinity of the abscess a large quantity of pus had escaped, the inner wall of the abscess being gangrenous. The rest of the condition you can imagine.

Here was a case which illustrated very strikingly the advantage of Dr. Watkins' method. If that localization had been determined upon the second or third day, and vaginal incision and drainage undertaken, there is no doubt in my mind but what the life of that patient would have been greatly prolonged, and possibly saved by the drainage of that abscess, and the removal of the pus in that condition.

I consider the method of extreme value and should be adopted in all cases of puerperal infection. When we know an abscess has localized itself, I would agree with Pryor that vaginal incision and drainage is indicated in puerperal cases where the tendency for the fluid, which accumulates in these cases, is to gravitate to the cul de sac, and these cases may be drained and relief afforded.

**Edward H. Ochsner**, of Chicago: I must emphatically disagree with some of the statements made by the essayist, and I do not think we ought to let them go by without giving our reasons for disagreement. He has told us that the mortality, so long as the pathologic pro-

cess is in the acute stage, is much greater than after the fever begins to subside. That is a statement for which we have fought for the last five years in all conditions of sepsis in the peritoneal cavity. We must wait for operative intervention in the great majority of cases, until nature shows the power of reaction and establishes a wall between the infective area and the general peritoneal cavity.

I certainly must disagree with the essayist in regard to the question of permanent cures. He tells us that ninety per cent. of these cases after vaginal incision and drainage are permanently cured. I am reasonably positive that this is not so. I do not doubt for a moment the Doctor's statistics. I have seen dozens of these cases, yes, hundreds of them, who have had peritoneal infection, some of whom were relieved by vaginal incision and drainage by ourselves, and others who were chronic invalids, who had chronic constipation, sallow skin, who were sick for a week or more every time menstruation came on, who had constant belching of gas, who had all the ills which patients who have peritoneal adhesions have. Many of them have been drained by ourselves and by others. We have resorted to vaginal incision and drainage in these cases time and again, and the patients have found it necessary to go to somebody else to get permanent relief. The reason for this is that simple vaginal incision and drainage of appendiceal abscesses does not cure the cases except in possibly thirty-three per cent. of them. If we contend that these patients are not cured after vaginal incision and drainage, how can we contend that the adhesions are absorbed? There is a radical difference. Connective tissue adhesions may become absorbed if there is no further focus of infection. The condition springing from an infected mucous membrane will practically never be relieved until that infected mucous membrane is either removed or destroyed by the process of necrosis. That is the fundamental reason why these cases of pyosalpinx drained per vaginam do not get permanently well.

Another point is this: We have found that patients who have been operated upon subsequently, after they have had vaginal incision and drainage, do not do as well as those patients who were primarily operated upon for pyosalpinx by laparotomy. The reason is this: In the ordinary pyosalpinx operation we have one bacterium which causes the infection, or one species of bacteria, to which the patient has become reasonably immune. About ninety-five per cent. of these cases will recover with a laparotomy. If you operate on a patient in whom drainage has been instituted, you then have the tissues infected by a variety of pus microbes, also by saprophytes, and if you operate on such a patient by laparotomy later, the mortality is greater than it would be if the patient were operated upon primarily by laparotomy.

Lucy Waite, of Chicago: I have listened with a great deal of interest to Dr. Watkins' paper, and I must say, that if I had written it myself I could not have expressed my own ideas any differently and more clearly, because

I agree thoroughly with the essayist. There is one point, however, which he did not mention, and that is with reference to routine treatment. We follow the procedures mentioned by him at the Mary Thompson Hospital in a very large per cent. of pus cases, pyosalpinx, pelvic exudates, etc., and if, after vaginal incision and drainage, the patients are kept in bed for weeks and given hot douches, these masses will, to a large extent, disappear. I am aware that vaginal douches are regarded as an old woman's remedy, but I certainly think they have a place in these cases. Of course, I realize that a number of cases must be operated on later; but, as Dr. Watkins has plainly stated, they are in a much better condition to be operated upon after the fever stage has passed. Not only that, if we follow the drainage and packing with hot douches, if a subsequent operation must take place, we have accomplished two things: (1) We have given the patient the only opportunity which we can give her to recover after a radical operation. (2) We have put the uterus, appendages, and the entire pelvic tissues in the very best possible condition for a radical operation, if it must be performed.

Dr. Watkins (closing the discussion): I wish to thank the members for the kind and courteous attention they have given my paper, and the thorough discussion that has followed its reading.

In regard to hematocele, I still think I might extend the indications rather than to make them less. Dr. Bacon will remember that not many years ago the indication in cases of hematocele was not to operate at all, and Professor Quine will, I think, bear me out in that statement, and that cases of hematocele recovered completely without any operation. To do a radical operation in cases of hematocele is very often a mutilating operation. The organs will completely recover by absorption without drainage. With drainage, they will recover more quickly.

I was very glad Dr. Reed brought up the subject of puerperal infection, because I think if there was any good in my paper, it was the part which dealt with puerperal sepsis, which I did not have time to read, and for the last two years in all cases of puerperal infection I have invariably made an incision back of the uterus for exploration, particularly in doubtful cases, and in two there was free pus in the peritoneal cavity, the patients subsequently recovering after that procedure. However, there were other numerous cases where there was free pus in the peritoneal cavity which did not recover, and which would not have recovered under any kind of treatment. So in puerperal cases, if the progress of the case is unfavorable after emptying the uterus, if there is any enlargement posterior to the side of the uterus, or if there are any acute signs of pelvic or general peritonitis, I believe in making a free posterior cervical incision.

Dr. Ochsner apparently misunderstood the paper, or I read it very badly. I did not contend that ninety per cent of these cases recover, but that ninety per cent of the cases I reported recovered. As far as the ultimate result of these cases is concerned, some of them



have been observed for a period of five or six years, and none of them have been operated upon within the last eighteen months. There is a possibility that some of them have passed from my observation. But when I looked over the histories I put in no cases that I did not have a chance to observe after they left the hospital. If only 25 per cent of them made complete recoveries, I would still do the same operation. I would in many cases make a vaginal incision during the acute stage, if necessary, even if they have to undergo a radical operation later. But I would reserve the radical operation for a time when the case was afebrile, and when the operation could be done with very little danger.

Dr. Ochsner makes a mistake in giving his reasons for waiting until the acute stage has passed. He says it allows nature to form a protective wall between the abscess and the rest of the body. I do not believe there is anything in that. What we accomplish by waiting is that the pus and toxins become less septic and the system becomes more accustomed to the toxins. If we wait until the febrile stage is passed, the pus becomes serum. Smears will fail to show any bacteria. Many cases of salpingitis undoubtedly get perfectly well without removing the tube. One might as well say that a case of septic enteritis never recovers, and if we were to contend that infection of a mucous membrane is never recovered from, then we would have to remove all infected mucous membranes, and soon we would be deprived of our mucous membranes which we use in respiration and digestion.

### "THE UNSURGICAL FEATURES OF VAGINAL HYSTERECTOMY."\*

BY S. C. STREMMEL, M. D., MACOMB.

Mr. Chairman—While my experience in vaginal hysterectomy has been limited as compared with many operators and while my results have been good in most instances, yet the few cases that have not been satisfactory, and from what I can glean from medical literature on this subject, I feel justified in the making the statements in this brief paper.

Vaginal hysterectomy was first done for carcinoma by Langenbeck as early as 1813; later by Sauter and Dubourge but very few of these operations were done until 1878, when Czerny brought it into prominence by improved technique and better results.

Since that time vaginal hysterectomy has met with considerable favor throughout the civilized world and today is done for almost

any pathological condition the uterus is heir to.

Formerly this operation was limited to carcinoma. Owing to the fact that many of these cases were not diagnosed or even seen by the surgeon until after regional infection had occurred, the disease returned in the majority of cases. In 1895, Emil Ries of Chicago first described an operation which consists of removing the uterus, adnexa and lymphatic glands, connecting with the uterus. It requires both vaginal and abdominal section. Since that time quite a number of these operations have been done and the results clearly demonstrate that it is as useless to remove a carcinomatous uterus, except in the beginning of the disease, without removing the chain of lymphatics connecting with it, as it is to remove the carcinomatous breast without removing the axillary glands. Therefore vaginal hysterectomy for carcinoma, except in the very early stage of the disease is an unsurgical procedure.

Vaginal hysterectomy is done today generally by one of two methods, namely, the forceps or ligature, many using both methods combined. The technique of this operation is modified in many ways by different operators. The forceps operation consists of clamping off the broad ligament and leaving the forceps in position for forty-eight hours or more when they are removed. These forceps extend into the peritoneal cavity. The fact is generally acknowledged by all surgeons that it is practically impossible to make the vagina thoroughly or even approximately aseptic.

This operation, therefore, subjects the peritoneal cavity to infection both during and after the operation, which seems to me, a most unsurgical technique. The fact that many of these cases recover with little or apparently harmless infection is strong evidence of the resistive power of the pelvic peritoneum and abdominal viscera to infection.

The ligature method consists of tying off the broad ligaments with two to six stout silk or catgut ligatures on each side. The number of ligatures used depending upon the technique of each individual operator.

\*Read at the 53d Annual Meeting, Quincy, May 20, 1902.



By this method the danger of infection during operation is the same as in the use of forceps, the peritoneum and viscera being exposed the same. It seems to be the consensus of opinion among most all operators that drainage of the peritoneal cavity is always necessary. Consequently these ligatures and pedicles are almost invariably infected and slough out. Some operators leave the ends of the ligatures long and at the end of four weeks take them out, sometimes a very difficult and dangerous thing to do. While as a rule, these ligatures come away with little or no trouble to patient or surgeon, yet oftentimes they do not, and become imbedded in the pelvic floor and cause suppuration for weeks and months before they pass away.

Most every surgeon has had experience with infected ligatures in the pelvis and can testify that they gradually work in the direction of the least resistance until they are discharged sometimes through the bladder, rectum, colon or vagina. These ligatures often cause pelvic abscesses weeks, months or even years after operation. The combined method subjects the patient to the unsurgical features of both and is seldom indicated. I have seen patients leave the operating room with two, four or six and even eight forceps hanging on and as many ligatures applied after the treatment being characterized by the foul smelling discharge due to sloughing of pedicles and suppurating of ligatures, a condition appalling to any one who has any regard for surgical cleanliness, especially so when he knows that the patient was free from suppurative disease before operation. It appears to me that patients who are subjected to such an operation and the risk of serious infection are the victims of an unsurgical procedure seldom seen in any other branch of surgery. Notwithstanding these facts, medical literature all over the world is full of glowing reports of this operation. Dr. Hall of Cincinnati at the Atlantic City meeting of the A. M. A. reported 100 consecutive cases without a single case of infection. Dr. Hall partially closes the peritoneal cavity leaving drainage. Many other operators report the

same brilliant results; results that are inconsistent with the general principals of surgery. In order to avoid the unsurgical features as herein described, an operation has been done which consists of removing the uterus in the usual way, using ligatures, and treating the resultant wound the same as wounds of the peritoneal cavity are treated elsewhere, namely, the complete closure of the wound by sewing up the peritoneum and vaginal mucous membrane. This operation, of course, can be done only in clean cases. I sincerely hope that time will demonstrate the success of this operation thereby avoiding the present unsurgical features of vaginal hysterectomy.

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### INTERCOMMUNICABILITY OF TUBERCULOSIS.\*

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BY D. J. D. MANDEVILLE, CHAMPAIGN.

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Since the world began, when the morning stars sang together and man, the masterpiece of creation, was created, disease and death have been abroad in the land, and birth, life, decay and death have been the role of the animal and vegetable kingdoms, while the other of the three great kingdoms has been exempt. And while there are many diseases that affect the animal, and many others that affect the vegetable kingdom, there are but few, if any, that are common to both. But, when we divide the animal kingdom into the higher and the lower, or the human and the brute class, we find that although there are many diseases that are peculiar to each, there are a few that are common to both classes, and they are those that are the most fatal when once encountered and belong mostly to the infectious class. Among them are Tuberculosis, or Consumption, Diphtheria, Charbon or Malignant Pustule, as it is sometimes called, Glanders, and Hydrophobia. The first mentioned, viz: Tuberculosis, or Consumption, is the one to which I desire to call your attention for a short time, as it is by far the most common, and being so insidious in its

\*Read at the September Meeting of the Champaign County Medical Society.

contagiousness, it is the most to be feared, and therefore more especially demands our attention.

Tuberculosis is a disease that affects all ages, and while none are exempt from its baneful ravages, still it is quite rare in persons over fifty years of age, quite common in infancy and childhood, but most prevalent between the ages of eighteen and thirty. Why this is so, I cannot tell, but it is true that there is a certain something about the youth and vigor of manhood and womanhood of life, for which this Fell Destroyer has an affinity. It seems to crave for and hunger after the best and richest blood of our race. The young man or woman that has scarcely completed the growth period, and it may be just fresh from the college or university, and perhaps hand in hand with loving companion, is ready to enter life's battlefield to struggle for an existence, yea, for wealth and fame, easily becomes its victim and readily succumbs to its baneful, death dealing microbe.

Tuberculosis is one of the most, if not the most, destructive of the great scourges that prey upon the human family. Its fatality ranges anywhere from twenty to thirty per cent of the mortality rate of our race. Then, if this be the case, if Tuberculosis is the prime factor in from one-fifth to one-third of all our deaths, it is high time for investigation as to cause, prevention and treatment, and more especially the two former, viz: cause and prevention, and as prevention is preferable to cure and prophylactics to treatment, it behooves us as lovers of humanity, to put forth every effort to prevent its rapid spread and arrest it in its onrushing career.

It is generally conceded now, and I think I may say proven beyond all doubt, that its cause is the presence in the system of a micro-organism or germ, which is called a Bacillus or Bacterium. It was said of Saul that he had slain his thousands and David his ten-thousands, but this diminutive Giant (for he is small in size, but a giant in power) has already slain his myriads of millions and still the work of destruction goes on, and yet, notwithstanding all this, the

little demon was first formally introduced to our race but a few years ago. He was first discovered in 1882 by Robert Koch, of Berlin, who had but a short time previously been appointed on the Sanitary Board of that city, but previously he was a chemist and bacteriologist of the obscure town of Walenstein in Germany, but his discovery and subsequent investigations have made him the world-renowned Koch. And it is now generally conceded that there is no Tuberculosis without the Bacilli, and their presence in the body is sufficient to establish the diagnosis of Tuberculosis, and is positive evidence of the disease.

Tuberculosis is world-wide in its reach, and no country or race of people are exempt from it, but it is most prevalent and fatal among that class of people that live indoors—as the inmates of factories, shops, almshouses, and prisons, and is the most destructive to life of any disease that is common to both human and the brute family; and this in part accounts for its prevalence, as it is so often communicated from the higher to the lower class, or vice versa.

A little over a year ago the renowned Koch made the startling announcement that the Bacillus producing the disease in the human and brute were not identical, but were distinct and separate species, but the recent investigation of such scientists as Dr. Salmon, chief of the bureau of animal industry, and of Dr. Dinwiddie, a careful experimenter, affirms that they are not very dissimilar and that Koch's assertion is not based on sufficient scientific evidence, while Dr. Ravenel, of the veterinary department of the University of Pennsylvania, has proven that they are interchangeable and belong to the same Tubercular Bacilli group.

Until within the last few years there has been little, if any, doubt of the unity of the cause of the disease in the human and brute family, viz: that the germ or bacilli in the two families were one and the same, but at present there seems to be a divergence of opinion upon this subject, some holding to the opinion that there are two distinct dis-

eases, while others believe to the contrary, and while both are citing cases and reporting experiments in support of their belief, I think the preponderance of evidence is largely in favor of the latter: viz, that it is one and the same bacterium that is causing all of the trouble and that it is common to both families, human and brute. And we believe that we have positive proof in a great many instances of the communicability of the disease from brute to man, and from man to brute, and from brute to brute. Among the lower animals we find it prevailing in the following order or ratio, Cattle, Fowls, Rodents, Pigs, Goats, Sheep, and Horses, while carnivorous animals, such as Dogs and Cats, are rarely affected with it, and White Mice cannot be given the disease, even by injection or other modes of infection.

I will speak of the disease as it relates to the animals that we have the most to do with, viz: Cattle, Poultry and Pigs, they are the ones that are most susceptible to the disease, especially Cattle, hence the prevalence of Bovine Tuberculosis over all other forms of it.

In a recent test of Cattle for Tuberculosis, made in the United States, we have the following report:

Vermont .....	3.9
Massachusetts, suspected herds.....	50.0
Massachusetts, entire herds.....	26.4
Connecticut .....	14.2
Illinois, 1897 and 1898.....	12.0
Illinois, 1899 .....	15.0
Minnesota .....	11.0
Michigan .....	13.0
New York, 1894 .....	6.0
New York, 1897 and 1898.....	18.0
Pennsylvania .....	14.0
New Jersey .....	21.0
Iowa .....	13.0
Wis. Ex. Station, suspected herds....	35.0
Wis. Ex. Station, non-suspected herds.	9.0
Wis. State Vet. Test, suspected herds.	32.0

The high per cent of tuberculous cattle in the above report is explained on the ground that only suspected herds have been tested, while it is believed by state veterinarians, that are in a position to know, that not more

than from eight to twelve per cent of the cattle in the United States are affected with the disease. But, when we cross the water to foreign countries, more densely populated, we find the disease much more prevalent. The Slaughterhouse Statistics of Prussia show 14.6 per cent of all cattle and 2.14 per cent of all swine to be tuberculous. In Saxony, 29 per cent of cattle and 3.10 of swine. In the City of Leipsic, 26.4 of cattle and 2.17 of swine. In Belgium, of 20,850 cattle tested with tuberculin, in 1896, 48.88 per cent reacted as evidence of having the disease in one form or another. While in Denmark, that great dairy country, 25,439 cattle tested with tuberculin, 1893 to 1895, showed that 49.3 were effected with the disease, while 67,283 head tested in 1896 to 1898, showed only 32.8 per cent infected. An examination of 20,930 cattle in Great Britain, either slaughtered and examined post-mortem, or tested with tuberculin, showed 26 per cent affected with tuberculosis, and an examination of herds with tuberculin, known to be infected with the disease, shows from 27 to 90 per cent infected.

Now, in the face of all of these statistics and many others that I might give, what conclusion must we come to? If from eight to twelve per cent of all of our cattle and fifteen to twenty per cent of foreign cattle have tuberculosis, and the parasite or bacillus causing it is the same but common to both human and brute (or even if there are two distinct diseases, which may yet be proven and both diseases are common to both human and brute family), are we not forced to the conclusion that the Bovine animal is furnishing a vast breeding ground and seeding ground for the propagation and spread of this disease?

I have referred more particularly to the Bovine, and why is it that the disease is more common with cattle than with any other of the lower animals? In solving this question the following explanation may be of some use to us: The normal temperature in the human is 98.5 degrees Far., while in most of the lower animals it is higher, as for instance, in cattle, it is 101 to 102 degrees; in hogs, 104 degrees; in sheep,



103 to 104 degrees, and in poultry 106 degrees.

It is a well-known fact that the Tuberculosis Bacteria thrive best in a temperature of 101 to 102 degrees, and in making culture or growing and multiplying them outside of the body, our culture mixture or culture media should be kept at about that temperature, and we find in the Bovine a normal temperature, viz: 102 degrees, that seems to be just suited to the requirements of Bacillus, as the farmer would say, the soil is all prepared and the temperature is just right for the sowing of the seed, and if the seed is good, we may expect rapid germination and growth. In the infected human, where the disease exists in a latent form, it does not seem to thrive very well as long as the temperature remains normal, viz: 98.5 degrees Far., but when a sufficient temperature is generated by some other disease, as for instance, malaria, pneumonia, or any disease accompanied by fever, we find the soil is ready for the growth and development of the germ, and our patient has consumption or some other form of tuberculosis. Every seed has a soil preference, and while it may live in other soil, it thrives best in a soil that is adapted to its own peculiar requirements. Again there are soils that are so constituted that a variety of seeds may, when deposited in them, grow and bring forth an abundant harvest, and while the germ of consumption seems to thrive best in its own soil at a temperature of 101 or 102 degrees Far., it will live and multiply at a lower or higher temperature, but not so well.

In regard to the inter-communicability of Tuberculosis from man to brute, or *vice versa*, there seems to be a divergence of opinion, and more especially so in the last two or three years, and I think this is largely due to lack of knowledge and to prejudice; to lack of knowledge, I say, because so many of the post-mortem examinations in the bovine are made by incompetent persons, who on failing to find pus and enlarged glands, pronounce the animal healthy, while an expert or even an ordinary bacteriologist

would detect the bacillus in an apparently healthy animal: and to prejudice, I say, because until state and national laws are so framed as to liberally compensate the farmer and dairyman for his cattle that are slaughtered by state veterinarians, there will be a prejudice against the use of the tuberculin test.

In regard to inter-communicability of the disease, I think that we have sufficient literature upon this subject to convince the unbiased mind that tuberculosis is inter-communicable. I will first cite a few cases that go largely to show that it has been communicated from brute to man, and for the following reports, I am indebted to various writers that have reported them for different medical journals.

1st. One report is that in a young ladies' boarding school, five girls, the children of healthy parents, died of tuberculosis of the intestines, and the cow that had supplied the school with milk for years was found to have General Tuberculosis, including the udder.

2nd. Two daughters of a Scotch family of good health, who were brought up on milk of tuberculous cows, died of tuberculosis, while two sons of the same family, who did not use the milk, remained healthy.

3rd. A child five years old, of sound parentage and ancestry, died of Tuberculosis. The cow whose milk this child used was found to be badly tuberculoused.

4th. Four children in the Infant' Hospital at Berne, the offspring of sound parents, died of intestinal tuberculosis; all other sources of infection were excluded and it was decided that they had been infected with milk from tuberculous cows.

5th. Mention is made of a twenty-one months old child that drank the milk of a highly tuberculous cow for one week, while on a visit to its uncle, and three months later died of intestinal tuberculosis. Other sources of infection were excluded, while a second child brought up on sterilized milk from the same cow, remained healthy.

6th. Another case is reported of the death of a boy, aged four years, at Yonkers, N. Y., from Tubercular Meningitis, where

the infection was traced to the milk of two cows, which proved upon post-mortem examination to be tuberculous.

Another report is that of the death of three children of one family from tuberculosis, that had used the milk of a cow of advanced tuberculous, even to the udder.

Leonhardt, of Massachusetts, reports the death from tuberculosis of the Meninges, Intestines and Mesentery, of two children, fed on the milk of a tuberculous cow.

Another is that of a veterinarian, thirty-four years old, of a healthy family, and in good health, who pricked his left thumb while making a post-mortem examination of a tuberculous cow. The puncture healed without suppuration, but in about six months there formed a hard cutaneous tubercle at the seat of the scar. The man began to cough, and died of tuberculosis in about eighteen months afterwards, and upon opening the scar or tubercle on the thumb, it was found filled with a caseous mass, extraordinarily rich in bacilli.

Dr. M. B. Hartzell, of one of our Eastern cities, reports the case of a healthy man, weighing 175 pounds, who was employed by a railway company to work upon cars used for the transportation of cattle. He was wounded upon the hand by a piece of broken woodwork of a car, and typical tuberculosis developed locally. Within a year his general health began to decline, accompanied by a cough, expectoration and dullness at the apex of the left lung, which was soon followed by death from general tuberculosis.

A very interesting case of sub-cutaneous tuberculosis, caused by the local application of cream for some trivial ailment, was reported by Dr. A. Grotham. The family were using the milk of one cow only and inoculation of two rabbits with milk and cream from this cow caused tuberculosis in each.

These are only a few of the many experiments reported in the different medical journals, of the communicability of the disease from animal to man, and now I will recite a few cases in which it has been communicated from animal to animal and from man to the lower animal.

One report is that of a whole litter of pigs being fed on milk from a tuberculous cow; a few weeks afterwards the pigs were slaughtered and the tuberculous bacilli were found abundant in every one of them.

Another report is where the pigs were fed the uncooked flesh of a tuberculous animal, and upon being slaughtered the tuberculous bacilli were found abundant.

Another instance is recorded where flies, the common house flies that had lived in the room of a consumptive and lived upon the sputum of the patient, when the flies were killed and the intestines examined, they were found thickly inhabited with the tuberculous bacilli; hence the necessity of seeing that all food or articles that are to be used as food, are kept so that flies cannot have access to them, or else we should see to it that the food is so thoroughly cooked as to destroy all germ of life.

To prove the contagiousness of the disease from man to animal, I will report the following cases: Some six or seven years ago I had a typical case of consumption in a man aged 27 years, in which the tuberculous bacilli were abundant in the system. Some of the sputum was furnished to a bacteriological student at the University of Illinois; he injected some of it into the back of a mouse; quite an extensive ulcer formed at the point of the inoculation and the mouse sickened and died in about two months, and a post-mortem examination showed abundance of acute miliary tubercles in the lungs.

Some of the virulent sputum was then fed to a rabbit, and in about one week there was a rise in temperature from 101 to 104 degrees Fahrenheit, with considerable emaciation, but in three weeks it began to improve and pick up in flesh, and the temperature gradually fell to the normal point, and the recovery was complete. It was fed on clover, corn and carrots and kept in the warm basement of the Natural History Building. There was no post-mortem, hence the proof is not positive.

At the British Congress for the Prevention of Tuberculosis, held in London during the summer of 1901, Dr. Robert Koch

reports having fed a number of young cattle on tuberculous bacilli taken from human tuberculous sputum, and that they were absolutely insusceptible to the infection, while Delepine fed human tuberculous sputum in sterilized milk to a calf and the animal died in twenty-six days, and a post-mortem examination showed tuberculosis of the glands, of the intestines and also of the oesophagus. Another calf was inoculated by injection of the same sputum and a post-mortem examination seventy days later showed tuberculosis of the peritoneum.

The above are but a few of the many cases that I might recite to you, but lest I weary you, I will not tax your indulgence farther by doing so, but with these facts staring us in the face, what are we to do? If tuberculosis is inter-communicable, and I think the medical profession and the laity are largely of that opinion, is not the presence of large numbers of tuberculous animals a great source of danger, and is it not our duty as sanitarians to urge the making and enforcing of such laws, State and National, as will largely tend to abolish it or at least largely decrease its mortality rate. I believe what has been done with other pestilential diseases, such as smallpox and cholera, can be done with tuberculosis. When we, as a people, are once aroused from our state of lethargy to the vital importance of rigid, persistent action.

Much has been written in the religious journals of the last few years of the importance of the individual communion cups, for fear of tubercular infection, and they have been adopted in some of the city churches, and while such infection is possible, and I acknowledge it as a step in the right direction, I think it is a very short one.

What per cent of our people ever touch their lips to the communion cup? I am sorry to say it is a very small per cent, and the danger of infection here is incomparably small as compared with the thousand other avenues left wide open without any restrictions whatever. Then let us, as lovers of humanity, look beyond the communion table and urge the enactment of laws that will give protection, not only to church commu-

nicants, but will protect the whole human family, and then we may expect to stamp out the disease.

A mistaken idea that some people have is that the disease only affects poor, under-fed cattle, but statistics show the better class of cattle are the ones that are more often affected, and the pure bred cattle that are being constantly imported to this country for breeding purposes are the means by which some of our finest herds have been infected. Of the fine herds owned by the different State Agricultural Colleges, we find the following report:

	Per cent infected with tuberculous bacilli.
Massachusetts Agricultural College	.....78
New Jersey Agricultural College	.....60
Vermont Agricultural College	.....64
Ohio Agricultural College	.....46
Texas Agricultural College	.....48
Wisconsin Agricultural College	.....86
Kansas Agricultural College	.....27
Maine Agricultural College Experiment	

Station so badly diseased that the entire herd had to be slaughtered.

An animal, apparently in good health, may have the disease in a latent form, for it is sometimes so insidious in its progress that we often fail to detect it until the tubercles begin to soften, break down and suppurate, and then it breaks forth in all of its fury, but the chances are that it is too late to yield to medical treatment. In proof of this I will report one case of the latent form of the disease which came to my notice some three or four years ago. A farmer and stock raiser butchered a nice three-year-old steer for his own use. The animal was in fine condition, but upon opening it the intestinal and mesenteric glands were all enlarged from the size of a pea to a pullet's egg, and the larger ones were just ready to break down, and upon being opened were found to contain caseous matter and pus in abundance. This I examined with the microscope and found it to contain abundance of tuberculous bacilli. I then sent some of the glands to Prof. Burrill of the University of Illinois, and sections of the glands were given to the class in bacteriology, and



they confirmed my diagnosis by finding tuberculous bacilli in abundance.

Before finishing my paper, I wish to correct one mistaken idea that is quite prevalent: viz, that tubercular milk must come from a cow with tuberculous udder in order to convey the disease to a person, or to another animal, but such is not the case, for reports from the different experiment stations show that less than two per cent of the cows that have the disease have a tubercular udder; a cow in apparently good health may be giving tubercular milk sufficient to infect the milk of a whole dairy.

It is not my intention to exaggerate or overestimate the danger from tuberculosis, but in view of these reports and many, many others that I might give you, is it not our duty as sanitarians and lovers of humanity to see to it that there is no stone left unturned that will help to expedite this matter and rid our land of this deadly scourge. The death rate in New York City alone is nearly ten thousand people annually. What would the people of that city do were smallpox, scarlet fever or any other disease to kill ten thousand of its citizens annually? Would they not be up in arms at once? And yet tuberculosis nearly does it every year, but they either do not know it or else have become so accustomed to it that they think it a natural, inevitable consequence, and hence give the matter little or no consideration.

Dr. Azel Ames, who had charge of the smallpox hospital in Porto Rico, said that the average death rate from smallpox in that island, for ten years preceding American occupation, was 651 in a population of 960,000, but after the American authorities made vaccination compulsory, and after its enforcement, there were but two deaths per annum. Now, in view of these facts, may we not reasonably expect as good results in our attempts for the control and suppression of this disease as have been obtained for the lowering of the death rate in smallpox, cholera, typhoid fever and other contagious diseases, if we but put forth the same effort for the enactment of sanitary laws, quarantine, and if needs be inoculation?

## EXOPHTHALMIC GOITRE\*.

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An account of the theories proposed to explain the nature of exophthalmic goitre is, in itself, a sort of psychological study. The literature upon the subject has grown to enormous proportions. The most complete discussion is to be found in Koehler's monograph, *Ueber Morbus Basedowi* published this year in Jena and containing an exhaustive bibliography with 1,423 references. The number of hypotheses that have been suggested, the warmth with which they have been defended, and the fragile bases upon which they have been erected, exhibit anything but the true spirit.

Without attempting a *resumé* of all these views and arguments, I purpose to examine critically only the two principal ones now in vogue and to indicate, if possible, which, in my opinion, has the stronger arguments in its favor. Of course it is to be understood that no explanation of the disease, even at this time, is entirely satisfactory. We are still as ignorant of the real nature of exophthalmic goitre as ever.

The older of the two views which I wish to bring before you holds that in exophthalmic goitre the central nervous system is at fault. The trouble is principally and entirely a central neurosis, this term being the best that we can employ, poor as it is. I will not stop to consider the many attempts to localize this process in the medulla oblongata (Filehne, Durdufi, Bienfait, Sattler, Fitzgerald), the cerebral cortex (Newman), or the peripheral nervous apparatus, including especially the vaso motor sympathetic system (Abadie.) Enough for the present that this hypothesis assumes that there is a functional disturbance, toxic or quasi-physiological, within the cellular elements of the central nervous apparatus and that all of the symptoms of the disease, such as the tachycardia, the goitre, the exophthalmos, the tremb-

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

ling, the hyperidrosis, are the results of the neurosis and are in no way dependent one upon another.

The other theory of the disease, and the one extremely popular at the present time, is the so-called "hyperthyroidation" or "dys-thyroidation" theory. This explanation was first made by Mobius of Berlin in 1886 and has been ably supported by Wette and Muller in Germany, Joffroy, Brissaud, Regnault and Boinet in France, Bramwell, Murray, Adam and Greenfield in England, and Starr and others in America. In accordance with this view, the primary disease is in the thyroid gland which thereby produces an excessive or altered secretion, which secretion acts somehow upon the nervous system to bring about all the phenomena of exophthalmic goitre except the goitre. This theory is right in line with the general trend of modern science to assign a toxic cause for most of the ills that flesh is heir to. The toxic idea is always a convenient one to fall back upon in these days of bacteriology, ptomaines, leucomaines, etc. Some hold that this excessive and altered secretion of the thyroid gland is the toxic substance; others maintain that the poisonous substance is the result of the normal metabolism of the body, which substance or metabolic process is not antagonized as it should be and is by the normal thyroid secretion.

Both of these views, the nervous and the glandular, have strong support among the authorities. Both rest upon a certain amount of experimentation and clinical observation. Both are incomplete, and yet both have been advocated as though they were positively established. Since argument, logical deduction and inference have played so important a role in the advocacy of both theories, it is perfectly legitimate in criticising them to employ the same method to analyze the strength of the premises, the correctness of the logic and the justness of the conclusions drawn from the data at hand.

There are four theories based upon the supposed etiological importance of the thyroid gland and its secretion:

1. There is an *altered* thyroid secretion which acts *directly* upon the nervous sys-

tem deleteriously (direct thyroid intoxication).

2. There is an *excessive unaltered* thyroid secretion which possibly through its iodine or thyroiodine acts *directly* upon the nervous system (direct thyroid overstimulation or paralysis of inhibition).

3. There is an *excessive and altered* thyroid secretion which fails to perform its normal function of neutralizing the deleterious products of the normal body metabolism, which products are thereby allowed to injure the nervous system (indirect thyroid intoxication).

4. There is an *altered* thyroid secretion, which may or may not be excessive, but which fails to check the *accumulation* of the products of the normal body metabolism, which products hurt the nervous system by reason of their mere accumulation (indirect thyroid intoxication).

The nervous phenomena, which even the thyroidationists admit, constitute the whole of the symptomatology of exophthalmic goitre, except the struma, are all secondary both as to sequence and etiological importance to any one of these four manifestations of the diseased gland and its secretion. In a word, Graves' disease is essentially and primarily a disease of the thyroid gland. The nervous phenomena bear the same relation to the disease as the nervous manifestations of typhoid fever or of Bright's disease bear to these pathological processes. To maintain this thesis, the thyroid change should be demonstrable beyond all peradventure in every case, and it should possess, at least, all of the testimony in its favor which the neurotic manifestations now possess in theirs. The nervous phenomena are self-evident and are more or less obvious in every case. Is disease of the thyroid gland equally self-evident and uniformly demonstrable? The presence of the nervous phenomena is recognizable by everybody, but are the believers in the glandular theory ready to assert upon the data already at hand that the affection of the thyroid can be demonstrated in every case of exophthalmic goitre? Suppose it is shown that the thyroid is dis-

eased in every case, the real question still at issue would be whether the disturbance of the nervous system, which is so obvious, precedes or follows the functionally altered thyroid. So overwhelmingly prominent are the nervous symptoms that some of the strongest advocates of the gland theory are beginning to beg the question by affirming that the alteration in the function of the thyroid gland has its origin somewhere and somehow in the nervous apparatus, while the more prominent symptoms of the disease are to be attributed to the thyroid. Marie thus straddles the fence and calls attention to the fact that exophthalmos never occurs in myxoedema when the thyroid extract is administered. Dana argues that the nervous system first affects the thyroid and that this again, through its altered secretion, reacts upon the nervous system. Vetlesen, Londe and many others believe that the hypersecretion which gives rise to most of the symptoms of the disease is itself brought about by an original disturbance in the nervous system. The whole question is thus thrown into a state of almost inextricable confusion. Let us see if we can give any distinctness to the points at issue and then we will be in a better position to assign the proper valuation to the various arguments and data in favor of the thyroid or neurotic theory.

If the altered thyroid is the cause of exophthalmic goitre, obviously it should precede in time all of the other symptoms of the disease. This it does not always do. The goitre is often absent or late in developing. Cases of Graves' disease without struma have been observed by v. Graefe, Dusch, Pauli, Trousseau, Maekenzie, Degranges, Fisher, Raymond, Hitschman, Charcot and others. Gordon records that Savage found in the District of Columbia only one case of Graves' disease among one thousand goitres. Occasionally the thyroid recedes in size while the other manifestations of the disease continue or even increase. Flint had under his observation for three years a case in which there was no material change except that the thyroid enlargement disappeared. The pulse remained habitually at 140. There seems to be no apparent relationship between

the size of the goitre and the severity of the other symptoms of the disease. One thing is quite noticeable, however, and that is that the struma is very rarely, if ever the earliest symptom. Irregularity of the heart's action is usually the first sign. The order in which the symptoms appear is far from being settled among authors. Nothnagel enumerates them as exophthalmos, struma and tachycardia, while Jaccoud says it is palpitation, dilatation of the arteries, enlargement of the thyroid and exophthalmos. Many questions await an answer in regard to the nature of the change in the thyroid by reason of which it gives rise to the particular set of symptoms recognized under the name of exophthalmic goitre. We must know more of the nature of the thyroid secretion; whether indeed it is a toxin. As a matter of fact, we know absolutely nothing about such a substance, the mere discovery of and experimentation with the iodine constituents not being satisfactory. We know scarcely anything about the normal function of the thyroid gland and how can we therefore predicate anything of certainty with regard to the abnormal gland?

In regard to the special way in which the thyroid secretion acts to bring about Graves' disease must needs be explained. It must be shown how the gland secretion exerts its influence directly upon the nervous elements or indirectly upon the body metabolism to provoke a definite, regularly recognizable set of symptoms which, so far as we now know, are not produced by any other toxin or glandular secretion. In the normal thyroid a substance has been found, principally combined with a proteid, although also free. This is known as *thyroidin* or *iodothylin*. It contains 9.3 per cent of iodine and 0.56 per cent of phosphorus. Jaunin noted the similarity in the manifestations of severe iodism and exophthalmic goitre and said that he believed that chronic iodism or thyroidism was the cause of the latter disease. Gautier confirmed Jaunin's observations. Boinet cited cases of Graves' disease produced directly by the consumption of large quantities of thyroid substance and stated that he believed the iodine in the



thyroid was the cause of the symptoms. Many others have expressed the same opinion. In spite of the fact that iodine and the iodides have been deemed positively harmful in the treatment of this disease, cases are constantly being reported in which both their internal and external administration have proved beneficial. I have seen good results follow the exhibition of the iodides and hydriodic acid. Gowers refers to these remedies without commending or condemning them. Oppenheim says that potassium iodide may be tried but must be used cautiously. Dana mentions the iodides as among the few remedies that have given him good results and notes that many writers now lay great stress on the direct treatment of the thyroid gland by rubbing it daily with the red iodide of mercury or by painting it with iodine. One would fancy that if the disease symptoms are due to a hypersecretion of the thyroid gland and especially to the iodine in it, that the iodine treatment should be as heartily condemned as the treatment by means of the administration of thyroid substance. To clinch the argument, as it were, that it is not the iodine, whatever else it may be, that causes the clinical picture of Graves' disease, A. M. Starker comes forward with a case in which myxoedema resulted from the long use of iodide of potassium for another affection. In passing let it be noted that Durdani claims to have produced symptoms closely resembling those of Graves' disease with cocaine.

In addition to the composition of its secretion, we must know many other things before we can dogmatize about the normal or abnormal action of the thyroid gland. For instance, we must explain away or account for in terms of its function many questions in regard to heredity, age, sex, temperament, all of which seem to play so prominent a role in the etiology of exophthalmic goitre.

As we all know, heredity is found in a large proportion of the cases of Graves' disease. Rarely it is direct, as in the cases cited by me; more often there are antecedent nervous troubles, such as hysteria, epilepsy. Heretofore it has not been shown that glandular diseases are so strikingly sub-

ject to the law of heredity as Graves' disease seems to be. It is true that certain tendencies run in certain families, as for instance, weakness of the lungs, of the heart or of the stomach, but no such heredity has ever been postulated of these or any other organs outside of the nervous system that has been attributed to the thyroid gland. It cannot be said that it is merely the usual susceptibility of the nervous system that is inherited in this disease, for the heredity is too pronounced and occasionally too direct (eight members of one family in one instance) to be ascribed merely to so indefinite a condition as susceptibility. On the other hand, if it is answered that it is the peculiar nervous influence preceding the disturbance of the gland function which is the cause of the heredity, it may be said that that is begging the question, for with such an explanation the thyroid secretion cannot be justly considered the cause of the disease any more than can glycosuria be regarded as the cause of diabetes mellitus.

Again, it has been thought that there is some connection between the sexual apparatus and the thyroid gland. It is said to undergo changes at puberty, though the physiologists do not specifically mention any such connection. It is an accepted fact that the thyroid function plays an important role in the general metabolism of the body and the metabolic functions are powerfully influenced by the great climatic periods. Thus the inferred connection between the thyroid and the sexual glands may be merely one of simultaneous and coincident activity without there being any closer intimacy. At all events it is argued that the etiological importance of the thyroid gland in exophthalmic goitre is shown in the supposed relationship between the thyroid and sexual functions because it has been observed that sex, pregnancy and the puerperal state are significant as predisposing in the causation of Graves' disease. Of course this leaves entirely out of view the much older and better established observation that these same features, sex, pregnancy, etc., affect most profoundly the nervous system of the woman and for that reason are

quite competent to predispose to the production of exophthalmic goitre without the necessity of the intervention of a modified, though perchance related thyroid function.

Admitting that the thyroid gland does show changes suggestive of its relationship with the sexual organs, it is to be remembered that Graves' disease occurs in women ten times more frequently than in men—Trousseau says fifty to eight—and that it must be shown that there is a correspondingly large functional if not structural difference between the thyroid glands of men and women normally. This difference has not yet been demonstrated. Exophthalmic goitre is sometimes called a "woman's disease." Hysteria and certain other neuroses are also female diseases, merely by reason of the influence of their peculiar sexual lives upon their nervous systems. The nervous apparatus of the woman does not differ *per se*, so far as we know, from the nervous system of the man and is only unlike his in being subjected to certain powerful influences of a physiological nature in connection with the sexual organs. This brings about an *apparent* difference between the nervous systems of men and women. The thyroid gland is subject to nervous influences of a powerful sort, and this is probably the reason it manifests an apparent difference in function at least, in men and women. The frequency of exophthalmic goitre in the female sex seems to me to argue in favor of the neurotic rather than the glandular origin of the disease.

The thyroid gland seems to be enjoying a high degree of popularity these days as a cause of disease. The brilliant results obtained from its administration in myxoedema and cretinism have stimulated the profession to look upon it as the source of many affections whose symptoms are the opposite of these diseases. Already Graves' disease is attributed to it, and we are asked to believe that paralysis agitans as well as myoclonus familiaris are also dependent upon it (Lundborg).

Because certain changes are found in the gland in these various diseases, it is assumed that these changes antedate and are the cause of the nervous troubles instead of

*vice versa*. The assumption is a bold one but needs a great deal more proof than is now in hand before it can be accepted as final and conclusive.

The age at which exophthalmic goitre usually begins and is most frequent seems to me to argue against the thyroid and in favor of the neurotic origin of the disease. It is seen in all periods of life, childhood as well as old age, but most commonly in the second decade of women and the third of men. Those who see a relationship between the thyroid and sexual functions explain this upon the ground that the second and third decades of life are the periods of the greatest sexual activity. Is it not a bit illogical to attribute, as is too often done, pathological tendencies with histological changes in certain glands, upon the ground of mere physiological activity? There is no contention, observe, that the thyroid gland is over-active at this time but merely that during this period of highest physiological activity in the sexual organs the supposedly related thyroid is brought into higher but still physiological activity. The ovaries and mammary glands are aroused into greater activity also during this period, but they are not said to become diseased from this cause alone.

There is a closer relationship and similarity both in the time and degree of sexual activity between men and women than there is in the relative frequency of exophthalmic goitre between them.

A word in regard to the onset of Graves' disease. Most cases appear gradually but not a few come on with great suddenness, usually after a great mental shock or other profound nervous disturbance. Bartholow has recorded a case in which the first symptom, protrusion of the eyes, was noticed by the patient on going to a mirror on the morning after having experienced a great shock the night before. A sudden physical strain and prolonged, exhausting labor have not infrequently eventuated in a rapid onset of exophthalmic goitre. It is difficult to understand just how these cases are to be attributed to an altered secretion of a gland whose substance must presumably undergo a time-consuming change.

The association of exophthalmic goitre with hysteria, epilepsy, mental deterioration and other neuroses has been noted by the hypersecretionists who explain that these neuroses render the nervous system specially predisposed to yield to the deleterious influence of the altered thyroid secretion. Their explanation, however, explains too much, for in that case we should meet with Graves' disease more frequently than we do among hysterics, epileptics and the insane, since they not only suffer from goitre without the production of the exophthalmic variety but the larger percentage of the disease occurs in people who are neither hysterical, epileptic or of unsound mind. Whatever the predisposing neurosis may be, it is not these, though it may be closely related to them.

The symptomatology of exophthalmic goitre speaks loudly in favor of its being a nervous rather than a glandular disease. Not only are the symptoms preeminently neurotic quantitatively but qualitatively as well. They constitute the clinical picture and are so manifest that even the supporters of the glandular theory recognize the fact that clinically Graves' disease is a nervous disease, though they attribute these neurotic manifestations which are so obvious to a glandular secretion which is so obscure. The victims of the disease are very irritable, apprehensive, lachrymose, subject to insomnia, impairment of memory, diminished power of application, headache, vertigo, tremors and various hysterical manifestations. Bulimia followed by anorexia is not uncommon. In addition to these, the frequent absence of the goitre, the early appearance of the tachycardia and the relative prominence of the exophthalmos, together with all the secondary symptoms such as the trembling, the hyperidrosis, v. Graefe's sign, pigmentation, decrease of electrical resistance, etc., point clearly to the nervous system as the affected part of the organism. These symptoms form so remarkably uniform and well recognized a picture that one rarely has difficulty in making a diagnosis. It has been suggested that under the name exophthalmic goitre there are included several diseases, just as there are sev-

eral kinds of diabetes. However that may be, there cannot be any doubt about the distinctiveness and individuality of the symptom-group known as Graves' disease. Whether we believe that the seat of the neurosis is in the sympathetic system, the vaso-motor centers of the medulla, the restiform bodies or the cerebral cortex, the fact remains that it is always more or less the same parts that are affected. Therefore we must suppose either that the thyroid secretion possesses some mysterious selective power or that these particular parts of the nervous system are especially susceptible to that secretion. As the toxin is here still present and active, its influence upon the nervous system is comparable to the influence of the syphilitic virus as seen in cerebro-spinal syphilis rather than in locomotor ataxia. Cerebro-spinal syphilis is notorious for the irregularity and uncertainty of its manifestations, whereas, locomotor ataxia, being a mere sequel of the syphilitic storm, is a regular, definite disease, with a regular, uniform clinical picture. Clinically exophthalmic goitre has the same systematic regularity that locomotor ataxia has, and yet the hypersecretionists would have us believe that it is the result of a cause which, according to all rules of analogy, should give rise to a set of symptoms as bizarre, irregular and uncertain as are those of cerebro-spinal syphilis!

What explanation with the thyroidation theory are we to offer of the fact that the gland enlarges twice as often on the right side as on the left, and that the exophthalmos, when unilateral—as it is in rare instances—occurs on the same side as the enlargement of the gland? Even the hyperidrosis is at times unilateral.

Another difficulty which presents itself in connection with the symptomatology of exophthalmic goitre and which is quite unexplainable upon the thyroidation theory is that the vascular enlargement of the gland follows the tachycardia and vaso-motor disturbance. Hypersecretion is physiologically always dependent upon increased vascularization. In this case, however, it is assumed that the vasomotor excitement which provokes the increased vascularization of the



gland does not precede but follows hypersecretion. There are two possible escapes from the dilemma. In the first place, it may be assumed that in the beginning of the disease there is not an excessive thyroid secretion, but merely an altered one, and that this altered secretion excites the vasomotor apparatus to a sudden and increased vascularization of the gland. On the other hand it may be suggested that the structural condition of the gland and its secretion are not the same after as before the tachycardia and other vasomotor disturbances have appeared. Not only are both of these and kindred explanations without demonstrable proof, but even as explanations they are more tortuous and less clearly indicated than is the view that the tachycardia is primarily a nervous trouble which together with the vasomotor disturbances produces later on the enlargement of the thyroid gland and its resultant hypersecretion.

The pathological findings are not even strongly confirmative of the hyperthyroidation theory. The changes discovered in the thyroid gland are not always constant and uniform and such changes as have been found are not always associated with the symptom group known as exophthalmic goitre. According to Marie there is no line of distinction to be drawn between the thyroids of exophthalmic goitre and ordinary bronchocele. Joffroy and Achard have voiced the same opinion. Vandervelde and Le Boeuf examined four cases histologically with great care and found the goitre of Graves' disease exactly the same as ordinary goitre. On the strength of these observations they rejected the hyperthyroidation theory. Brissaud refers to exophthalmic goitre as "a group of symptoms rather than an independent disease," and then notes that changes in the thyroid gland were observed in twenty-five cases of various chronic diseases. As these changes did not give rise to the exophthalmic group of symptoms, it looks very much as if the gland changes were due to the nervous trouble.

Very little is known in regard to the supposed altered secretion of the thyroid gland, and as to its mode of action we have nothing but theories and hypotheses. Gley found in

Graves' disease that the thyroid secretion contained only one-tenth as much iodoprotein as normally and the general view is that the change in the secretion which brings about the nervous manifestations of the disease involves principally the iodothyron. It has been argued that the toxic theory of the disease is strengthened by the fact that the urine of persons suffering from it is highly poisonous. Donath, however, found no iodine in the urine of normal individuals or those fed with iodothyron in doses of 1.8 mg. This poisonous urine, moreover, does not produce any condition at all resembling exophthalmic goitre when injected into dogs.

In accordance with the hyperthyroidation theory the employment of belladonna in the treatment of the disease ought to afford most gratifying results. Some authorities do claim good results from the use of belladonna but by far the majority have found this drug quite ineffectual. The best treatment for the disease has been found to be absolute rest, physical and mental, electricity, certain surgical procedures and nerve sedatives such as codeia, opium, hyoseyamus and the bromides. It is hardly supposable that the effect of these nerve sedatives is merely to quiet and suppress the nervous manifestations of the disease, while the abnormal activity of the thyroid gland continues, for if that were so, all of the nervous phenomena would immediately return the moment the treatment were discontinued. Only two theories are possible to explain the success of the sedative treatment in this disease, and that is that either the thyroid change is the result of a disturbance in the nervous system or that the whole disease is primarily neurotic in origin and continuation. In both instances the thyroid gland is of secondary importance in regard to the etiology and pathogenesis of exophthalmic goitre.

The uncertainty as to the advisability of using iodine, the iodides and hydriodic acid in the treatment of this disease springs largely from the supposition that the iodothyron of the thyroid secretion plays a prominent role in its causation. In accordance with the hyperthyroidation theory they are strongly contraindicated and yet, as I have already pointed out and have witnessed in

my own experience in some few cases they have proved beneficial.

The same may be said in regard to the use of thyroid extract. Before it is to be irrevocably and dogmatically condemned a better founded explanation of the disease than is found in the hyperthyroidation theory should be forthcoming and some adequate reason given for the occasional case that recovers after the administration of the thyroid substance. One of my cases is now free from every sign of the disease after taking the thyroid extract in 5 grain doses three times a day on and off for two years. Another case still under observation failed to respond to other lines of treatment but is improving with the use of two grains of the extract three times a day. In both of these cases the patients themselves feel that the thyroid treatment is the most effectual for them and when I suggest a change of treatment they offer strong protests. It is no argument in favor of the hyperthyroidation theory that in a large majority of the cases the administration of thyroid substance provokes an increase of the symptoms. Thyroid substance often provokes nervous manifestations when given to healthy individuals and in other diseases. I have under observation a mild case of sporadic cretinism in a child six years of age in which very small doses of thyroid extract cause marked nervous phenomena. All that is proved by the increase of symptoms provoked by the administration of thyroid substance in exophthalmic goitre is that in this disease the nervous system is weak and preeminently susceptible.

In connection with this question of the administration of the thyroid gland I would like to call attention to the fact that exophthalmic goitre and myxoedema are not, except in some minor and very superficial respects, opposite or antithetical diseases as is so triumphantly asserted by the upholders of the hypersecretion theory, and that all inferences drawn from the use of thyroid extract in the treatment of myxoedema will fail to assist us in making assumptions in regard to its avoidance in Graves' disease. The thyroid gland may and does produce, as physiologists tell us, more than one se-

cretion, and upon the strength of this the hypersecretionists may some day be able to demonstrate the reason for the somewhat apparently opposite character of some of the symptoms of these two diseases. That they cannot possibly be due to opposite states or modes of action of a single thyroid secretion is proved by the observation of the two sets of symptoms in the same patient at the same time. A remarkable example of this was recorded by Pasteur who ended his report with the words, "It is interesting to note that the patient presented simultaneously some of the signs and symptoms of Graves' disease and of myxoedema. For in association with a persistent exophthalmos, a smooth skin, tendency to perspiration and occasional marked tremor of the hand we find an apathetic demeanor, extreme sensitiveness to cold, some clumsiness of the fingers and alteration of the voice to a slight extent." Two cases of Sollier's reported by Bourneville, presented the coexistence of a generalized oedema with exophthalmic goitre. One showed all the characteristics of a genuine myxoedema and in both the thyroid, instead of being enlarged, was atrophied. All arguments for the hypersecretion theory of Graves' disease based upon its supposed antithesis to myxoedema thus fall to the ground.

Surgery has even been subpoenaed to bear testimony in favor of the hyperthyroidation theory. Four operations are performed, namely, thyroidectomy, resection of the sympathetic, ligation of the thyroid arteries and Jaboulay's "exothyropexie" (exposure of the gland to the air). Of these operations thyroidectomy is the most popular, and although its mortality ranges about 15 per cent, it is nevertheless resorted to when other treatment has failed, because in about half the cases operated on a cure follows. It is stated that these operations diminish the secretion of the gland by cutting off its blood supply or removing part of its substance. It is hard to comprehend how any one of the operations can restore an altered secretion though they may cause a diminution in its quantity. Somehow I am reminded, when I think of the success of these operative procedures in exophthalmic goitre of the cures that used to be heralded and were actually

accomplished at times in hysteria by operations upon the ovaries and uterus. Surgical shock will do wonders at times upon the neuroses. Curiously enough A. Pader and L. N. Robinson have expressed their belief that exophthalmic goitre is a form of hysteria and is due to the same causes, while Putnam intimates a somewhat similar belief when, after a study of exophthalmic goitre in its relation to emotionalism he concludes by saying that "it is a degenerative neurosis and marks one of the many lines of cleavage at which the nervous functions break when exposed to strain."

Still further, and finally, in support of the contention that exophthalmic goitre is a nervous rather than a glandular disease, Homberger found no specific insanity but all forms of insanity occurring with it.

In conclusion I must say, in the words of Oppenheim, that "the hypothesis which refers the disease to an abnormal increase in function of the thyroid gland is not very convincing." As both the hyperthyroidation and neurotic theories are still unestablished, after applying the same methods of reasoning to both, and studying both from the same given data, I am satisfied that the preponderance of evidence is strikingly in favor of the neurotic origin of the disease. The practical bearing of this conclusion lies in the rational explanation it affords of the treatment which we have discovered by experience to be the best and in guiding us possibly in regard to our therapeutics in the future.

#### References.

- Dana, Text-Book of Nervous Diseases.  
 Vetlesen, Zeitschrift fur Klin. Med., B. XXXVIII, H. 5 & 6.  
 Londe, Revue Neurologique, 1899, p. 788.  
 Gordon, Philada. Med. Jour., June 16, 1900.  
 Flint, Practice of Medicine.  
 Nothnagel, Med. Press & Circular, London, Nov. 27, 1889.  
 Jaccoud, N. Y. Med. Journal, Feb. 22, 1890.  
 Jaunin, Revue med. de la Suisse Rom., 1899, Vol. XIX, N. 5 301.  
 Gautier, Ibid.  
 Bionet, Revue Neurolog., July 15, 1899.  
 Starker, London Lancet, Jan. 10, 1891.

Gowers, Diseases of the Nervous System.  
 Oppenheim, Diseases of the Nervous System.

Lundborg, Deut. Zeit. fur Nerven.; Jour. of Nerv. et Ment. Diseases, January 1902, p. 56.

Joffroy and Aehard, Arch. de Med. exper. et d'anat. path., Paris, Nov., 1893.

Vandewelde, Jour. de Med., Bruxelles, Mar. 3, 1894.

Brissaud, Mercredi med., No. 34, 1895.

Gley, British Med. Jour., II, 771, 1901.

Donath, Zeit. fur Klin. Med., XXVIII, 1899.

Pasteur, Clinieal Soc. Transact. Vol. XXXIII, p. 189.

Bourneville, Sajous' Annual, 1893, Vol. IV, p. II. 5.

Pader, A. These de Paris, 1899.

Robinson, L. N. Ibid.

Putnam, Mass. Med. Soc. Reports, 16, 1893-1895.

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#### Discussion.

**Frank P. Norbury**, of Jacksonville: Mr. Chairman—This is one of the most interesting classes of cases that present many problems, especially along the line of etiology. I have seen some of these cases at the post-mortem, and in none have the pathological findings been uniform. The symptoms, especially toward the period of dissolution, were much the same and seemed to indicate a disturbance of the sympathetic nerves, and also a disturbance of the cerebral, namely, delirium, followed by disturbance of the thermal centers. This condition is very similar to that which we find after death from sunstroke, where there is encephalitis, and where the thermal centers have been very much disturbed. One case that I saw had a temperature of 106° F., which remained for two or three hours after death. Another case I had under observation several days, before death at a temperature of 105° F., and this case at the autopsy showed hemorrhagic conditions throughout the cortex, involving especially the medulla and extending down the cord; a hemorrhagic encephalitis. As the essayist has correctly stated, the question of etiology is still more or less obscure. Myxedema and exophthalmic goitre are probably the same in origin, and yet they are not treated alike. I remember a case of myxedema that failed to respond to thyroid medication with any degree of satisfaction, but, strange to say, it improved under the iodide treatment. The patient is now living, and the myxedema has very much improved, although I do not say that the patient has recovered.

The question of diagnosis, especially differential diagnosis, in young individuals, is often a perplexing problem. I have in mind the



case of a young girl, sixteen years old, in whom a diagnosis was made of acute tuberculosis. She was immediately sent to Colorado, with the hope of obtaining some improvement under climatic treatment. On her arrival there the heart symptoms were very much intensified because of the altitude, and her physician advised her to go to some ranch. She was unable to remain there, and went to Denver, where she came under the care of the late Dr. Eskridge, who immediately sent her back to her home in Illinois. The case was very obscure, because of the absence of the trilogy of symptoms, namely, rapid heart, enlarged thyroid, and exophthalmos. Although the exophthalmos was not a symptom early, it appeared later. I had the young lady under observation for some time, and she is now doing very nicely. I have had her under treatment for about two years. There was a late development of the menstrual function, and some disturbance of the temperature, which latter I have often noted, as if the thermal centers were in some way disturbed by the existing condition.

As to the sudden onset in some of these cases, I saw one case in consultation, a young lady, who developed the condition within twenty-four hours after a sudden fright. She was coming home from an entertainment one evening with an escort, when they were held up by a footpad. The young lady was very much overcome by the fright, and in twenty-four hours she developed an exophthalmic goitre which went through the usual course. The case was especially interesting because of the immense amount of edema or swelling of the limbs and the lower abdomen.

**C. B. Horrell**, of Galesburg: It is rather strange to see how very iconoclastic the specialist has become, and it is rather painful to see all our ideals shattered one by one. We older physicians, before the development of pathological investigations, were often led into mistaken paths. Take pneumonia, for instance; we were always led to believe that it is a disease of the lung; interstitial nephritis a disease largely of the kidney, and exophthalmic goitre a disease particularly of the thyroid gland. Now, we are being taught that pneumonia is an infectious disease, interstitial nephritis a cardio-vascular disease, and exophthalmic goitre a disease of the sympathetic system. One thing can be said of all these papers, and that is, if we wish to keep up in the profession, there is certainly a great stimulus given us by these specialists and investigators, which we must follow and take up or fall in the rear. These papers are all to be highly commended.

**S. E. Munson**, of Springfield: In a great number of cases of young girls that come into the hands of the practitioner during the period of puberty, from fourteen to eighteen years of age, there is an enlargement of the thyroid gland, and oftentimes a rapid pulse, but no apparent exophthalmos. When the parents notice this enlargement of the gland, they become very much exercised and worried about the girl, and I have oftentimes seen them take their daughter from under the care of a phy-

sician because, no matter what the treatment may have been, or what the physician's prognosis may have been, so long as the enlargement of the gland continued, they would be discouraged with any treatment. In some of the cases the two major symptoms do not appear. I should like to ask Dr. Mettler to speak about the prognosis of these cases in his closing remarks, and to say a few words as to the best methods of treatment.

**Marion K. Bowles**, of Joliet: I had the opportunity of studying four very marked cases of exophthalmic goitre, and my idea has been that they are a neurosis. The first case I had was of sudden onset, and terminated in three months. The patient had had an immense amount of work to do in her office as a real estate and insurance agent, and very trying business troubles had come up. So far as I know, the case developed in a very few days. I put her on iodides, and recommended absolute rest. She improved on this for about three weeks, when I very foolishly allowed her to have an hour with her clerk on the books. The hour was stretched out to half a day, and then her condition was as bad as when we began treatment. Nothing seemed to have any effect on her. I gave her thyroid extract, but found that she was getting gradually worse. The other three cases which I saw came on after some special expenditure of energy, and my previous experience prompted me to put the patients to bed and insist on absolute rest. I prescribed iodides and arsenic in all three cases. What was the best feature of the treatment I do not know. I would like to know what Dr. Mettler thinks of the rest treatment in these cases.

**E. R. Larned**, of Chicago: Dr. Mettler's remarks as to the sudden onset in some of these cases will, I think, have an important bearing in this discussion. I recall very vividly an occurrence which I witnessed in my former practice in the country. A certain life insurance examiner made a very careful examination of a proposed risk, and accepted it as a very desirable one. Six months afterward the individual was dead, and the diagnosis in his case was exophthalmic goitre. The medical director of the insurance company criticised the examiner very severely, on the ground that if the diagnosis was correct, there certainly must have been some symptoms present at the time the examination was made. The examiner unfortunately was relieved of any further connection with the company. If these cases come on within a few days, as has been brought out by the essayist, and some of the other gentlemen, it is important that particular stress be laid upon that point, so as to avoid any misunderstanding, especially in connection with life insurance work.

**Charles L. Mix**, of Chicago: There are some points connected with exophthalmic goitre which deserve further mention. First, exophthalmic goitre is, in all probability, not a disease, but a symptom complex, not attended by any particular set of symptoms in any one case, but attended by one or more of a large number of symptoms. We know perfectly well that

for every one typical case that we are called to see, there are four or five so-called atypical cases, cases in which the diagnosis is uncertain, and in which the diagnosis is deferred. Oftentimes, it appears to be a case of chlorosis, and iron is given in order to see whether it makes the patient worse. A point which possibly may have some bearing on the etiology of this disease, or, rather, a point which ought to be taken into consideration in the discussion of the etiology, is the association of this form of goitre with myxedema. This association of two diseases which are so utterly dissimilar is a very good indication of the fact that exophthalmic goitre is not a disease *per se*, but a symptom complex. I remember reading an abstract recently from an article in a St. Petersburg journal, which contained a very careful account of the association of these two conditions, and I, myself, have seen in at least one case this association, symptoms which clearly indicated a myxedema, and the ordinary signs seen in goitre.

With regard to the change that takes place in the thyroid gland in exophthalmic goitre with regard to the vascularity of the gland, I think that if it is to be typical, it should show a venous engorgement in the right lobe. The reason for this is very difficult of explanation. In one of the most pronounced cases I ever saw there was a large aneurysm, probably of the thyroid artery.

So far as the etiology is concerned, its connection with the sympathetic system must be taken into consideration. You all remember the operation for removal of the sympathetic ganglion in the cervical region. In some cases improvement followed, and in others not. Evidently there is a close relation between the sympathetic system and the thyroid gland in exophthalmic goitre. That is seen in the contraction of Mueller's muscle, which is supplied by the sympathetic. In many cases the tachycardia is due to direct stimulation or irritation of the cervical sympathetic.

**Dr. Mettler** (closing the discussion): I simply read my paper for the purpose of awakening discussion; and I wish to thank you very heartily for your reception of my effort. It has been shown very clearly that we do not know yet what exophthalmic goitre is, but the general impression seems to be that it is not entirely a disease of the thyroid, but very largely a nervous affection. I will say, in continuation of the remarks of Dr. Mix, that Abadie is bringing forth the old idea again, that exophthalmic goitre is principally a sympathetic disease. This is being brought forward forcibly at the present time.

With regard to Dr. Munson's remarks, as to the functional enlargement of the gland at the time of puberty, that, of course, influences the whole question of the diagnosis of goitre, and depends largely upon the question of the relationship between this gland and the sexual apparatus. I have seen those cases occasionally, but I do not believe that we are justified in calling them cases of exophthalmic goitre, as they do not manifest the typical symptoms.

With regard to the prognosis, some cases come on with the nervous symptoms strongly marked, and no exophthalmos until latter in the disease, and I find that these cases very frequently get well with absolute quiet and rest. I believe they are functional disturbances possibly brought about by changes in the girl's life, and giving rise to disturbances in the gland as well as in all other tissues.

In regard to the treatment, thyroid extract will make many cases worse, as has already been mentioned by Dr. Bowles. I am not advocating the treatment of the disease by thyroid extract, as I think it may, in the majority of cases, be said to be dangerous treatment, but I am trying to hold up the argument that the thyroid disturbance may not be responsible for the disease, and in that case thyroid extract may be beneficial. In discussing this question, a gentleman recently said that no person would think of administering thyroid extract in this condition, because it is positively known that it is a thyroid disease. Then I waited for his remarks as to the treatment. He said absolute rest and quiet were the very best treatment; not only physical rest but mental rest, with a change of surroundings; pointing thus very strongly to the neurotic origin of the disease. I would not be a bit surprised if we were to learn in the near future that in exophthalmic goitre various pathologic changes are found in the nervous system, a few having already been observed and reported, such as slight hemorrhagic conditions in the medulla, restiform bodies, and in the cortex.

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## A PLEA FOR THE MORE ACCURATE DIAGNOSIS OF CHOLELITHIASIS.\*

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BY J. H. STEALY, M. D., FREEPORT.

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A Review of Forty Cases, with a Consideration of Previous Diagnosis. An Enumeration of the More Important Differential Points Between the Above Conditions and Chronic Gastritis, Appendicitis, Renal Conditions, Hysteria, Neuralgia, and Sub-Phrenic Abscess.

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Despite the large amount of literature produced upon this subject and the discussions thereof within the last decade, from the standpoint of Pathologist, Internalist, and Surgeon, the uncertainties existing in the minds of the general practitioner in regard to the differentiation of this disease from obscure, because atypical, abdominal

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

troubles in general have very strongly impressed me in the review of my records of cases.

For purposes of illustration, and as the basis of this discussion, I have tabulated from my records a series of forty cases of disease of the biliary tracts, which have come to me through the hands of consultants. The large majority of these were either not diagnosed at all, or incorrectly so. And we must bear in mind that these cases by no means represent even a moderate percentage of people suffering with gall stones, under a false diagnosis, in the territory represented, for those patients coming to operation did so rather as a method of last resort for conditions which, while not considered as dangerous by the patient or his physician, had driven them, by their very chronicity, to this means of relief.

It shall be the object of this paper to take up and attempt merely to outline the points of differential diagnosis of only those diseases which in the following table were mistaken for biliary tract trouble, and it is to be noted that this discussion is mainly one of gall stones, present either in the cystic duct, or in the gall bladder, thus:

Table of Cases.....	40
1. Correct Diagnosis.....	23
History of Jaundice.....	18
My Own Patients.....	5
2. Incorrect Diagnosis.....	15

No. Cases.	Diagnosis.	Conditions Found.	Years of Disease.	Results.
3	Chronic Gastritis.....	13 stones in cystic duct, chronic cholecystitis.....	8	Recovery.
5	Chronic Gastritis.....	Gall bladder adherent to omentum and intestines.....	6	Recovery period 18 mo.
4	Appendicitis..	3473 stones in gall bladder, chronic cholecystitis. These stones are in N. W. Museum.....	8	Recovery, 5 years.
25	Appendicitis..	4 large stones, adhesions to stomach, omentum and intestines.....	2	Recovery.
20	Appendicitis..	Large number stones with adhesions to omentum and intestine.....	0	Recovery.
22	Appendicitis..	1 gall stone 63 gm., with thickening of gall bladder.....	0	Recovery.

No. Cases.	Diagnosis.	Conditions Found.	Years of Disease.	Results.
6	Malignant tumor of abdomen.....	1 stone $3\frac{1}{4}$ by $1\frac{1}{4}$ in....	0	Recovery.
7	Hysteria (Stomach)....	130 stones. Gall bladder atrophied.....	3	Recovery.
9	Hysteria (Stomach)....	5 large stones, with enlargement of gall bladder.....	2	Recovery; 11 mo. later malign. dis. uterus.
10	Neuralgia.....	Very large gall bladder 6 in. below costal arch. Cholecystitis, 2 large stones.	2	Recovery.
18	Gastralgia.....	5 large stones. Adhesions.....	9	Recovery.
23	Disease of Kidney and Stomach.....	Very cholaemic. Stones in common and cystic duct. Concluded operation.....	20	Died 6 hr.; shock.
26	Kidney Floating.....	T. B. peritonitis—chronic appendicitis. Gall bladder enlarged 992 s.....	20	Recovered died 2 mo. later
38	Sub-Phrenic Abscess.....	Large number stones cholangitis.....	5	Recovery.
28	Gastritis.....	No. stones chronic cholangitis, thickening of gall bladder wall.....	20	Recovery.

Cultures taken from these cases showed the colon bacillus.

From this series of cases may be elicited the following facts:

1. Of forty cases, twenty-three were correctly diagnosed.
2. Of these twenty-three cases, eighteen had no history of jaundice.
3. Of forty cases fifteen were incorrectly diagnosed.
4. Of these fifteen cases, gall stone disease were mistaken for:
  1. Chronic Gastritis, twice.
  2. Chronic Appendicitis, twice.
  3. Acute Appendicitis, twice.
  4. Malignant Tumor of Abdomen, once.
  5. Hysteria, with stomach trouble, once.
  6. Hysteria, once.
  7. Neuralgia, once.
  8. Gastralgia, once.
  9. Kidney and stomach trouble, once.
  10. Floating Kidney, once.
  11. Sub-Phrenic Abscess, once.
  12. Ileo-colitis, Uterine trouble, once.
  13. Gastritis, once.



5. That the aggregate length of time these fifteen patients suffered under these false diagnoses was 85 years, or  $5\frac{3}{4}$  years per patient.

6. That some cases were incorrectly diagnosed despite an inveterate jaundice, in two cases amounting to such a severe cholaemia as to result fatally.

There are undoubtedly many cases of an intractable chronic gastritis, which are in reality but a symptom of biliary tract irritation. And as a matter of course where but the symptom is diagnosed for the disease, that symptom will receive the treatment, with consequent failure. And this persistence of the gastritis despite our utmost effort at a cure, should cause us to seek deeper than the symptoms for the cause. Among the diagnostic points of this condition may be mentioned:

1. Character of attack as a rule much more severe than the pain incident to the partaking of food in gastritis.

2. Tenderness much more diffuse upon palpation.

3. With impacted stone in the cystic duct and atrophy of the gall bladder near the junction with the common duct we may have, as patients describe, a dull heavy ache or pain with nausea, which is increased by the introduction of food. This condition is not commonly accompanied with acute paroxysms of pain, and is as a rule the condition that is so often mistaken for a chronic gastritis. In many of these persistent gastric disturbances gall stones are not thought of owing to the youth of the patient. As a matter of fact, age is not such an important etiological factor as it was once considered to be.

4. Intervals between food taking may be attended by symptoms of delayed digestion and auto-intoxication as:

1. Eructation of gas.

2. Rumination.

3. Mental depression and headaches.

5. Presence of tumor, distended gall bladder, etc.

Finally 6 recourse should always be made to the stomach tube and the condition of the stomach contents ascertained:

Whether mucons be present.

Hypo or hyperchlorhydria.

Lactic, butyric, and other acid.

State of digestion of foods.

A point of considerable interest is that the symptoms simulating a gastritis are often of a more tangible character than a mere reflex action, in that the gall bladder may be directly adherent to the stomach, or duodenum, thus acting in a mechanical way towards the production of a gastritis.

*Appendicitis* is sometimes very difficult to differentiate from biliary tract trouble, and it will often tax the skill of the most experienced to do so. But inasmuch as both of these diseases as a rule call for surgical intervention the absolute importance of an accurate differential diagnosis can not be considered as great as the diagnosis of gall stones from a purely medical disease. In gall stones the previous history is often of value and suggestive, considering the etiology, as three-quarters of cases occur in females, typhoid fever, pneumonia, malaria, sepsis, puerperal fever and child birth. A previous enteritis, etc. Also a possible previous history of jaundice. The character of the pain may closely simulate appendiceal colic, beginning as a generalized pain and becoming localized, *but* it may occur that the pain is referred to the appendicular region, and here a close study of the order of the symptoms, as to the time of appearance may be of utility.

More generally in appendicitis, is there first the pain in the abdomen, then the nausea and vomit, the temperature and the localized tenderness.

*Movable Right Kidney.* In this case, it is a question rather of the diagnosis of the enlarged gall bladder, from a misplaced kidney, and not a question of subjective symptoms so largely.

In persons with thin lax parietes it may not be difficult to make out the outlines of the kidney, especially of the second and third degree (Futterer) where it may be possible to outline the form of the tumor, and in rare instances, get the pulsation of the renal artery. Ballottement renal should also be used.

The two bodies will resemble each other in that they may be:

1. Same size.
2. Distinctly defined.
3. Rounded.
4. Movable.

5. Both descend on inspiration (Robson.) In this particular there appears to be considerable variance of opinion. But, very generally on inspection the gall bladder can be detected as a tumor floating up against the parietes and moving with respiration. The kidney is rarely so. (Robson.)

2. The arc described by a movable gall bladder, will have a radius shorter, center under costal arch. The arc of kidney is longer or indefinite, and the center practically the same. (VanHook.) It may be depressed into the pelvis.

3. The gall bladder is pear shaped, the apex towards the fissure of gall bladder (P 98 Robson) and its long axis is in a line from about the tip of the 9 costal cartilage, downward, forwards and inwards towards a point a little below the umbilicus.

4. The gall bladder does not escape from the hand and tends to return to the original position when misplaced.

The kidney may escape the hand, and does not tend to return to the site in which found when moved. It has a tendency to remain in the loin. The kidney remains where placed, so long as patient maintains the horizontal position.

In examination and when in doubt as to the identity of the body found, always look for both gall bladder and the kidney, as very often both may be discovered by having the assistant hold gall bladder and getting the kidney between fingers and thumb.

5. A distinct sulcus is to be felt between lower margin of liver and gall bladder by laying the hand flat on abdomen and having patient breathe deeply.

6. May, in doubtful cases distend colon with gas. The kidney is covered by area of tympany. Gall bladder not so. (Ziemsens.)

Urine examination may disclose epithelium from pelvis of kidney in large amounts,

and blood cells. This is merely suggestive evidence. There may be traces of bile in the urine in gall stone diseases with no jaundice. This may be a valuable finding in the differential diagnosis. But we should remember that a movable kidney is a frequent companion of gall stones.

The renal colic will rarely be mistaken for hepatic colic, as the pain will be downward along course of the ileo-inguinal nerve, and rarely is so in hepatic colic. A urine examination for blood and detritus is here of great value.

*Hysteria.* Too often the tendency is to call "Neurasthenia," Hysteria, etc., those conditions whose cause we are unable to reach.

An hysterical attack may closely simulate a true hepatic colic including the tumor of the gall bladder by the "Phantom Tumor" due to the tonic spasm of one or more layers of the abdominal wall. We may get the gastric symptoms, and even some slight temperature reaction, and numerous of the visceral accidents, peculiar to this disease, but in this relation a very careful search will reveal—usually—the other stigmata of this disease, as

1. The mental characteristics of the patient, emotional, impressionable, and a general lack of will power.

2. Sensory, symptoms as reversal and contraction of the color fields of the retina.

The hyperaesthesias and anaesthesias segmentally arranged.

3. Motor symptoms, as the spasm, rhythmical and periodical.

4. Urine conditions, which is often a valuable aid as,

1. Reduction in total solids especially urea and phosphates.

2. Inversions of the proportions between alkaline and earthy phosphates, occurring practically only in hysteria (Church.)

But we must not lose sight of the fact that the hysteric may have biliary trouble, as may any normal individual. The use of the X-Ray should also be resorted to.

And lastly, in the consideration of this series your attention is called to the fact that of all those cases diagnosed as gall stone disease, correctly, as shown by the sub-

sequent operative findings, every such case presented an icterus of varying degree, whereas no case in the series, came with the diagnosis of bile tract disease, where jaundice was absent, thus showing the prevalence of the idea that jaundice is necessarily a part of the symptom complex of the trouble which is, of course, erroneous.

In other words 37.5 per cent of these cases had no jaundice, and 37.5 per cent were either not primarily diagnosed, or incorrectly diagnosed.

And when we consider that the average length of time these patients suffered under a false diagnosis was 5 3-5 years each, as a mere consideration of the alleviation of human suffering, a drawing up of our lines in regard to a more general and accurate understanding of the manifestations of hepatic trouble, is certainly to be undertaken.

### THE GASTRO-INTESTINAL TYPE OF INFLUENZA.

BY HENRY F. LANGHORST, M. D.,\* ELMHURST.

Hope classifies influenza into a common type, a nervous or neuro-muscular variety, and a digestive or gastro-intestinal form. The last named is the subject of this paper.

There have been two epidemics of the gastro-intestinal type in this locality in the present year. The first occurred in the early part of May, and the second in the latter part of October. Each outbreak was preceded by a marked precipitation in the temperature of from 8° to 10° F. The onset of the disease was sudden and the first symptoms appeared almost simultaneously in different families, remote from one another. The persons had retired, feeling perfectly well, and were awakened between 11 and 12 o'clock by a pain in the abdomen and a desire to defecate. They attributed their suffering to various articles that they had eaten the preceding day, and a number of instances were thought to be cases of ptomaine poisoning. In many families every member was stricken. The youngest

patient was a child of 18 months, and the oldest a woman of 50. The disease seemed to be more persistent in children. The duration of the endemic was about 4 days. Twenty per cent. had a recurrence of the disease, that is, they were afflicted during both endemics. Many complained only of transient symptoms, such as looseness of the bowels, backache and lassitude.

The marked depression so prominent in the other forms of influenza were not observed.

No attempt was made to find the Canon-Pfeiffer bacillus, but the symptoms justified the diagnosis of a digestive type of influenza. It was generally ushered in with a chilly sensation and general aching. Backache and headache were particularly complained of. The patient presented a flushed, feverish appearance, but the thermometer rarely registered more than 102.5°. The pulse varied between 80 and 100 and was of low tension. When asked to locate the pain, the patient would draw his hand across the epigastrium and describe it as a "cutting" pain, aggravated just before each bowel movement. There was but little tenderness on pressure. Nausea and vomiting were present in the majority of cases, and occurred especially after the ingestion of food. The bowel movements varied from 5 to 20 times daily, were of a serous type, and of a very urgent nature. Some mucus was present in the stools. Thirst was intense, and the urine was highly colored, but no albumen was observed. Anorexia was not present in all cases, and the tongue was but slightly furred. The attacks usually lasted from two to three days.

Complications in influenza are generally numerous and of a serious nature. In this type of the disease none were noted, except in two cases who had acute attacks of hemorrhoids.

The diagnosis was based on the endemic prevalent and the general aching and chilly sensations.

The patient was isolated from his family and put to bed in a warm room. It was recommended that the articles used in the sickroom, such as spoons, cups, and the like,

\* Member of Aux Plaines Medical Society.



be thoroughly boiled before being generally used. Although the stools were not disinfected, such a procedure would undoubtedly be of value, and will be practiced in the future.

Hot punch or lemonade was given, a mustard plaster applied to the abdomen, and the patient wrapped in a blanket. The resulting diaphoresis was always followed by some relief. As an auxiliary to this, a mixture of Potassium Citrate and Spirits of Nitrous Ether was given, combined as follows:

R Pot. Citrate.....3 drams  
Spir. Nitrous Ether.....4 “  
Glycerine .....1 ounce  
Simple Elixir qs. ad.....3 ounces

Of this one teaspoonful was given every two hours in half a glass of water for an adult. Water was given *ad libitum*. The diet was restricted to milk, and, in some cases, a total abstinence from food was ordered, as the ingestion would excite a vigorous peristalsis of the bowels or would make the stomach rebel.

The remedy of greatest value was found to be Betanaphthol-Bismuth in the form of Orphol. This combination of an antiseptic with an astringent acted admirably. It was given in doses of 10 to 15 gr. 3 to 5 times a day, in powder form, for adults. The vegetable astringents, such as Tr. Kino, and Tr. Catechu Comp. were also tried, but the best results were obtained from Orphol.

It is interesting to note that the profound depression and weakness and the tendency to complications so common to the other forms of influenza, were absent. This depression and weakness is at times so profound, that talking or the mere lifting of the hand is an effort. This was not observed, even when the stools numbered 15 a day. Either the infection was of an attenuated character, or the diarrhoea dissipated the toxæmia by the free elimination of toxins and bacteria through the serous outpour, and thus prevented the profound systemic intoxication and the many complications.

## REPEATED SMALL HEMORRHAGES AS A CAUSE OF SEVERE ANEMIA.

BY JAMES B. HERRICK, M. D., CHICAGO.

That recovery may rapidly follow a severe acute hemorrhage is well known. Even repeated severe hemorrhages may cause no permanent deviation from health, if the intervals between hemorrhages be sufficiently long to permit regeneration of blood to take place. The body may also stand repeated small losses of blood at shorter, even daily, intervals, with little or no perceptible change in the blood or in the performance of function on the part of any organ. Repeated hemorrhages from the nose, from hemorrhoids, from uterine fibroids may thus be endured for months or for years, the tolerance of the individual to the loss of blood and his power of blood regeneration being sufficient to withstand and make up for the daily drain. But in other instances, the daily loss of small amounts of blood produces the most severe and most fatal forms of anemia. It is my purpose in this brief paper to call attention to the importance of recognizing this form of anemia; and I treat the question from the practical and clinical, rather than from the hematological, point of view. My attention has been called to this subject by having seen five patients with bleeding piles in whom there developed a most grave secondary anemia. And I am led to write on this topic because in all of these cases the cause was for a long time overlooked and because in three of them even when the nature of the anemia had been pointed out, there was a disinclination on the part of some to regard so common and so insignificant a condition as bleeding piles as the cause of an anemia so profound and so clearly threatening life.

The first case I saw while acting as assistant to the late Charles Warrington Earle. Dr. Earle, after trying in vain by iron, arsenic, tonics, rest, etc., to restore color, strength and health to a previously robust man, decided to operate upon the bleeding hemorrhoids. The result fully justified his

suspicious as to the nature of the anemia, for the man made an uninterrupted recovery within a few weeks.

The second case was the wife of a physician. She presented the typical appearance, symptoms and blood findings of a severe chlorosis. For weeks she had been losing blood with every bowel movement, often several ounces at a time. Iron and other remedies were without perceptible effect. The immediate operation that I advised was deferred because of the weak condition of the patient, a slight temperature and the loudness of the hemie murmur which made the surgeon feel that there was an organic heart lesion that might account for the anemia and that contraindicated an anaesthesia. Several months later when the patient could scarcely walk across the floor without fainting, and when my second examination confirmed the previous findings of a grave secondary anemia, most urgent advice was again given as to operation. The hemorrhoids were attended to, the anemia disappeared and the patient has ever since been in perfect health.

A third patient, an old man in the sixties had an appearance suggestive of malignant growth. Yet there could be found for this profound anemia of the chlorotic type, no tumor, tuberculosis, nephritis or other cause than some hemorrhoids that had bled daily for nearly three years. He refused an operation and was lost sight of. His blood on May 18, 1901, the date of the first examination, showed 2,450,000 red corpuscles, 6,000 whites (74 per cent polymorphonuclear) no nucleated reds, haemoglobin 29 per cent. The cells were smaller than normal, volume index 72, the time of coagulation was four minutes.

The fourth case which I report more in detail concerns K, a Bohemian of 39. His family history was negative and he himself had pursued his occupation as a butcher, annoyed by no illness up to two years before the time I first saw him, the fall of 1901. In 1899 he had articular rheumatism and was kept from work for several weeks. From this he recovered. In September, 1900, he noticed that he was passing blood at stool.

The amount was often several ounces, frequently a half teacupful being passed. He grew pale, weak, dyspnoeic, dizzy and by May, 1901, could barely keep at work. His feet and ankles by this time were oedematous. Medicines seemed to do him no good and in August, 1901, he took to his bed which he had left only rarely since. The bowels moved once a day, a varying amount of blood being lost with nearly every movement. He was under my care for a time in the Cook County Hospital. Here a surgeon refused to operate on him until I had improved his general condition, saying the piles could well enough wait a while and needed only suppositories. The patient later came to the Presbyterian Hospital, and I quote from my records of the case while he was in that institution.

On examining him October 30, 1901, he was seen to be extremely pale, with a hint of a lemon yellow in the waxy whites of the eyes. He was somewhat emaciated, listless and apathetic as are many patients in the last stages of pernicious anemia. He was extremely weak. His lungs were clear. The heart showed no change except a systolic murmur, evidently hemie. The venous hum was marked. The abdomen and genitalia showed nothing abnormal. There was a slight oedema about the sacrum and the ankles. The rectum bled on digital examination, its walls were soft, there was no stricture. On straining he brought down several large hemorrhoids that dripped blood. The examination for motor or sensory disturbances was negative. The retina was negative. His urine contained no sugar, albumin or casts. He had an evening rise of temperature at times to 100. His pulse averaged 84, his respirations 24. The blood examination made October 29, 1901, was as follows:

Red corpuscles, 2,184,000.

White corpuscles, 4,200.

Hemoglobin (Fleischl, 3 tests) 19 per cent.

Color index, 0.44.

Time of coagulation, three minutes.

In the stained specimen the red corpuscles showed great variations in shape and size, the greater number being undersized. The

color of the corpuscles was poor and there was fairly well marked polychromatophilia. In a careful and prolonged search one nucleated red (of the megaloblastic type) was seen, and five normoblasts. Of the leucocytes the polymorphonuclear neutrophils made up 44.6 per cent, polymorphonuclear eosinophiles 3.0 per cent, small mononuclear lymphocytes, 35.7 per cent, larger lymphocytes 16.4 per cent. There were 0.3 per cent of basophiles. Many subsequent examinations were made by myself and by different members of the house staff. The results were practically the same. The hemoglobin reading was generally made by taking two or three capillary tubes of blood instead of one and dividing the total reading by 2 or 3 as the case might be, seeking in this way to lessen the possibility of error that so easily creeps in when the hemoglobin is low. In my office later, I also controlled by the Talquist color test. From these many examinations, I quote only some of the more pertinent findings. Nov. 4, the specific gravity was found to be 1034 by Hammer-schlag's method by two examiners. The volume index, i. e., the number of corpuscles found by the haematocrit divided by the number found by the haemocytometer, was estimated at different times and also found less than 1, varying from .66 to .86. The findings seemed typical of a severe anemia of the chlorotic or secondary type. The small size of the corpuscles, the abnormally low color index, the rapid coagulation, the scarcity of nucleated reds, those found being almost exclusively normoblasts—all this seemed to rule out the primary pernicious anemia. The bleeding hemorrhoids were looked upon as the probable cause and operation was decided upon. This was deferred for several days because of a peculiar and puzzling attack that the patient had on November sixth. November 4, he vomited also fainted while in the bath room. On the evening of November 5th, his pulse rose to 128, his respiration became short and shallow, 30 to the minute, his temperature reached 100.2. His muscles twitched and he became stupid and semi-comatose muttering to himself, picking at the bed-clothes,

having retention of urine. There was no paralysis. In twenty-four hours he gradually regained consciousness. The exact nature of this coma is not clear. It was probably some form of intoxication. Color is lent to this theory by the fact that for several days he had not only been taking good-sized dose of iron and arsenic, but he had been on full diet, in reality over-eating, with resulting gastro-intestinal disturbances. This may have been the source of the toxemia that in his weakened condition produced these alarming symptoms. During this attack the leucocytes rose to 14,800.

Following this attack he was kept quiet, given food more cautiously, also iron and tonics. His condition remained about the same as before. There were daily losses of blood. Late in November under cocaine anesthesia, as a general anaesthetic seemed too hazardous, A. D. Bevan, injected the four large hemorrhoids with equal parts of carbolic acid water and glycerine. Dr. Bevan admits that he was skeptical as to the hemorrhoids being the cause of the unusually severe anemia, but operated at my urgent solicitation. From that time up to April 12, 1902, when I last saw him, there had been no more bleeding. Iron has been continued, generally in the form of Bland's pill. The abbreviated blood counts are as follows:

Dec. 5, 1901—R. b. c., 2,784,000. Hb. 27.5 per cent.

Dec. 21, 1901—R. b. c., 3,800,000. Hb., 37 per cent.

Jan. 3, 1902—Hb. Fleischl, 61 per cent. Talquist, 60 per cent.

Feb. 21, 1902—R. b. c., 3,920,000. Hb. (Fleischl), 72 per cent.

April 5, 1902—Hb. Fleischl, 90 per cent. Talquist, 85 per cent.

For several weeks he has deemed himself to be as strong as ever, with no dyspnoea, having a good appetite and digestion. He has regained the appearance as to color and weight of a healthy man. He is prevented from working by a return of the rheumatic pains in his hands and feet. The joints have shown redness and swelling. He has had an occasional temperature of 99.4 when he has been in my office.



A case similar in many respects to this one was in the Presbyterian Hospital at about the same time, under the care of Palmer Findley. Through Dr. Findley's kindness I was enabled to see the patient several times. There was a history of bleeding piles for several years, the bleeding having been for ten months very severe. The ordinary anemic symptoms were present in the shape of dizziness, occasional attacks of syncope, palpitation, etc., and the same blood characteristics as in the other case, the hemoglobin being at first 18 per cent and the red blood corpuscles 1,952,000. An operation on the hemorrhoids was done and the patient continued to improve, though slowly. At the time of leaving the hospital, six weeks after admission, he had 4,016,000 red corpuscles and 36 per cent of hemoglobin.

The practical lesson to be drawn from these cases is perfectly plain. It is that severe anemia threatening life and producing a pallor and weakness equal to that of the pernicious variety, or suggesting some hidden malignant disease, may at times be caused by repeated small hemorrhages often from a condition as easily recognized and easily remedied as hemorrhoids. This form of anemia may prove fatal; and cases of a transformation of the type into the pernicious are reported especially by English writers, and Ehrlich inclines to the belief that the pernicious variety may have its origin in repeated hemorrhages. The careful blood examination showing the chlorotic or secondary type of anemia should give encouragement for immediate measures looking toward a checking of the hemorrhage. The hemorrhage once stopped, recovery, though it may be slow, is generally complete.

#### PROCEEDINGS OF STATE SOCIETY.

Minutes of the Fifty-Second Annual Meeting Held at Quincy May 20-22, 1902.

#### THIRD GENERAL SESSION.

The President called the general meeting to order.

The Secretary read a telegram from the Missouri State Medical Association in ses-

sion at St. Joseph, extending greetings and best wishes.

On motion of Dr. George N. Kreider, the telegram was ordered placed on file, and greetings sent to the Missouri State Medical Association by the Secretary.

The report of the special committee, to whom was referred part of the report of the Judicial Council, was read by Dr. Joseph Robbins, as follows:

To the Illinois State Medical Society:—Your Committee, to whom was referred so much of the subject-matter of the report of the Judicial Council as relates to the influence which this Society, as the representative of the medical profession of Illinois ought to exercise upon the character of medical appointees to State institutions and State boards, where such appointments are required by law, begs leave to report that they have had the subject under careful consideration.

The Committee is in accord with the Judicial Council in its conclusion that to make this influence effective, there must be a responsible committee to act for this Society in the interval between the annual meetings.

In commending most heartily the work of the Judicial Council along this line, as disclosed by its report, the Committee desires to remind the Society that the best part of such work is and must be unrecorded. Enough is disclosed, however, to make it plain to your Committee that it is not easy to lay down any hard and fast rule for the government of such responsible Committee as the Council has in mind, or to map out any plan from which the varying exigencies of different cases may not require a deviation.

In view of these considerations, and in view also of the encouragement afforded by recent events that the powerful influence of the Executive may be exercised to bring about sooner than we had hoped the enactment of such civil service rules relating to the charitable institutions of the State as will secure the objects at which we aim. Your Committee is of the opinion that it is unwise to adopt any hastily devised, untried plan along these lines, and therefore recommends that the responsible committee to act

therein for the Society during the recess be the Judicial Council itself, whose conservative and sagacious course has demonstrated its ability to handle the work to the best interests of the profession.

To this end the Committee offers the following:

Resolved, That the subject-matter of this report be referred to the Judicial Council with power to act.

Respectfully submitted,

Joseph Robbins,

D. R. Brower,

H. N. Moyer,

J. W. Pettit.

W. F. Grinstead,

Committee.

Dr. Robbins moved the reception of the report, with the adoption of the accompanying resolution. Seconded and carried.

Dr. J. W. PETTIT: Among the questions considered by the Committee, and which were regarded as not within the province of the Committee, because it was introducing new business, was the question of endorsement of civil service rules. Therefore, I offer separately from the report of the Committee, as an individual, and not for the Committee, the following preamble and resolution:

Whereas, The ultimate aim of this Society in attempting to make its influence felt in the matter of medical appointments is what is accomplished by the application of the civil service rules in the management of charitable institutions; therefore, be it

Resolved, That this Society will heartily support the enactment of a civil service law to apply to all the charitable institutions of this State, which will take all appointments, medical or otherwise, out of the realm of partisan politics.

On motion, the resolution was adopted.

Adjourned.

#### MAY 22 — THIRD DAY — MORNING SESSION.

The Society was called to order at 8:30 a. m., by the President. As there was not a quorum present for the transaction of business, the general meeting adjourned, and Section Two was called to order by the Chairman.

#### SECTION TWO—FOURTH SESSION.

Dr. Edward H. Ochsner, of Chicago, read a paper entitled "Congenital Dislocation of the Hips, with Report of a Case."

Discussed by Dr. Schroeder.

Dr. T. J. Watkins, of Chicago, read a paper entitled "Vaginal Section and Drainage for Pelvic Disease," which was discussed by Drs. Bacon, Dunn, Reed, Ochsner, Waite, and the discussion closed by the essayist.

Dr. O. B. Will, of Peoria, read a paper entitled "The Limitations of Surgery in Gynecology," which was discussed by Drs. Watkins, Simpson, Stremmel, and, in closing, by Dr. Will.

Dr. S. C. Stremmel, of Macomb, followed with a paper entitled "The Unsururgical Features of Vaginal Hysterectomy," which was discussed by Drs. Watkins, Reed, and, in closing, by the essayist.

Dr. E. A. Fischkin, of Chicago, read a paper entitled "Remarks Upon the Treatment of the More Common Skin Diseases."

Dr. J. Rawson Pennington, of Chicago, read a paper on "Hemorrhoids; Their Pathology, Indications for, and Technique of, Operative Treatment."

Discussed by Dr. Reed, and, in closing, by the essayist.

The following papers were read by title: "Congenital Phimosis," by Dr. C. C. Hunt, of Dixon; "The Use of the Curette in Puerperal Sepsis," by Dr. George L. Eyster, of Rock Island.

This finished the work of Section Two. The Chairman, Dr. Mammen, thanked the members for their courtesy and co-operation in enabling him to carry out the program.

On motion, a vote of thanks was extended to Drs. Mammen and Schroeder for their excellent work.

At this juncture the general meeting was called to order by the President for the transaction of such business as would come before the Society.

The Secretary read the following resolution by Dr. Fenton B. Turk, of Chicago, who asked that the Society adopt it:

Resolved, That we are in favor of introducing into the medical colleges of the United States practical teaching in die-

tetics, physio-mechanical therapeutics, and hydrotherapy.

On motion of Dr. Webster, the resolution was laid on the table.

The Secretary read the following preamble and resolutions concerning the abolition of the newspaper publication of personal medical advertisement:

Whereas, It can and has been shown, by ample statistics, that the American race is rapidly decreasing in its birth rate, thereby threatening ultimate and complete decadence of the race; and

Whereas, Such decadence has become so apparent that it should claim the serious attention of those of influence and power to in any degree lessen this evil; and

Whereas, Without a special effort to investigate, it must have been observed by the most indifferent with what flagrant violation of all sense of delicacy the public press gives place to advertisements of nostrums and means intended to prevent or cut short pregnancy; these advertisements appearing in a column of the paper set apart for such purpose under the name of "Personal Medical Advertisements," and referred to as "Guarantees," "Sure Relief," "Sure Prevention," etc., occupying in some Sunday editions of reputable papers as much as two columns, destined to fall into the hands of all classes; and

Whereas, We recognize the press as a most potent factor in the education of the masses; be it

Resolved, By the Academy of Medicine of Kansas City, Mo., that we respectfully recommend that a censorship over the press should be exercised to the end of correcting such practice of publishing advertisements as those referred to in our whereases. Be it further

Resolved, That it should be deemed of sufficient moment for the attention of the Post Office Department of the United States of America restricting or prohibiting the distribution of such papers, periodicals or magazines through the United States mail if they continue to so prostitute their columns with such matter; and be it further

Resolved, That a copy of these resolutions be sent to every State Medical Society in

the United States, urging their co-operation in this movement by the adoption of these resolutions.

Resolved, That we request the Secretary of every State Medical Society adopting these resolutions to forward two copies, one to the American Medical Association, and the other to the Postmaster-General, petitioning for relief from this destructive influence.

John W. Kyger, M. D.,  
H. C. Crowell, M. D.,  
B. H. Zwart, M. D.,

Committee.

THE PRESIDENT: What disposition will you make of these resolutions?

DR. J. W. PETTIT: While I believe that this Society is in hearty sympathy with the spirit of these resolutions, yet I do not believe a matter of this kind ought to be adopted hastily or in any irregular manner. Therefore, I move that the resolutions be referred to the Judicial Council, with instructions to report back at the next annual meeting of this Society. Seconded and carried.

#### REPORT OF COMMITTEE ON NOMINATIONS.

The next thing in order was the report of the Committee on Nominations, which was read by the Secretary. The names of officers elected will be found on the 3d advertisement page of each monthly issue.

The President declared that the action of the Nominating Committee in this instance was final.

On motion of Dr. Ochsner, the Secretary was instructed to consult the Secretary of the American Medical Association and ask for more than three delegates to represent the Society in the A. M. A., according to its present membership.

DR. J. W. PETTIT: The actual membership of this Society, I understand, up to the time of the adoption of the new Constitution and By-Laws, was practically thirteen hundred; but the actual membership under the new Constitution and By-Laws will perhaps be approximately thirty-five hundred or thirty-six hundred. These facts ought to be made clear to the Secretary of the American Medical Association. The Secretary, however, can attend to this matter.



The President then announced the standing committees:

#### STANDING COMMITTEES.

See list of officers.

**THE PRESIDENT:** I wish to say, that I received a request from Dr. Wyeth, the President of the American Medical Association, to name a representative for the National Conference on Medical Legislation at Washington, and I named Dr. Carl E. Black.

Dr. C. S. Bacon, of Chicago, offered the following resolution of thanks:

Resolved, That the thanks of the Society be extended to the local committee of arrangements and to the citizens of Quincy for the cordial and hospitable manner in which we have been received and entertained; also, that our thanks be extended to the Supervisors and officials of the court house for halls and rooms in which to carry on the business of the Society.

On motion, the resolutions were adopted.

**THE PRESIDENT:** The next thing in order is the installation of the officers-elect for the ensuing year. I will ask Dr. Bacon and Dr. Pettit to escort the President-elect, Dr. Harris, to the platform.

Before resigning this office, I have a word or two to say. I feel very grateful and thankful that the Session, which is just coming to a close, has been a very successful one. We have had an excellent attendance, and a most excellent program. We have all profited by the attendance, and have enjoyed the sessions. I want to thank you all for the cordial sympathy and support you have given me during the year in prosecuting the work of the Society, and I bespeak for my successor in office the same cordial sympathy and support. I am glad we have chosen for our President for the ensuing year a gentleman who is prominent in the profession from Chicago. That is a great field for work for the coming year. Organization has been prosecuted quite actively throughout the State, and a large number of counties throughout the State are already organized. Before we come to another annual meeting, I trust we will have all of the counties in Southern Illinois organized, and the work will undoubtedly be prosecuted throughout the State along this line of organization, and

in another year we may expect the State to be fairly well organized and our membership very largely increased.

Dr. Harris, I have the great pleasure of presenting to you this emblem of authority (gavel), to govern the Illinois State Medical Society. Gentlemen, I present to you your President for the ensuing year, Dr. Harris. (Applause.)

Dr. Harris, in accepting the Presidency, said:

Gentlemen: In accepting the Presidency of this Society, I wish to state that I am in hearty accord with the principles of our new Constitution which we have adopted, and while there are some minor changes which must be made, and which experience will dictate, still I feel certain that the principles embodied in this Constitution will do more toward the unification of the profession in this State than any step which the Society has taken in many years.

I am also in accord with the liberal spirit which is manifest in this Constitution concerning the admission of members to the Society which heretofore were excluded, and feel certain that guarded as the Society will be by the House of Delegates and Judicial Council, nothing but good can come from this liberality of spirit. While I am not unmindful of the great honor which, through your kindness, has been conferred upon me, I know and feel that there is work to be done, and were I to rest on the empty honor of being elected President, I would feel that I would not only disgrace myself, but disgrace my friends who have reposed confidence in me, which would be the greater evil. I appreciate the honor more than my words can express, and I thank you very, very much.. (Applause.)

**DR. J. W. PETTIT:** In appreciation of the remarkable work that Dr. McAnally has done for the Society during the past year, I move that a vote of thanks be extended to him. In making this motion, I want it to be considered more than a formal empty honor. I would call your attention to the fact that to Dr. McAnally, more than to any other one man, and probably to more than any other dozen or twenty men, is due the fact that stars are plastered over the

Southern part of the map of Illinois which has been exhibited to you. Southern Illinois has been the most difficult part of the State to organize, for reasons which it is not necessary to explain, and of which I know full well. I want to call your attention to the fact that there are more county organizations in Dr. McAnally's territory than in any other part of the State. For this great work we are greatly indebted to Dr. McAnally, and the men he has rallied about him. He was elected last year for that specific purpose, and the work has been well done.

In extending this vote of thanks, I wish to remind you, as one of the members, that this is the purpose of the Society, and we shall expect Dr. Harris to go into Cook County and do equally as good work as Dr. McAnally has done in the Southern part of the State, no matter what the obstacles may be, and I hope that a motion will be made that we pledge unreservedly, individually and collectively, the support of every member of this Society, and especially those present, to co-operate with you, Dr. Harris, in that work.

DR. C. S. BACON: I would like to second the motion and the words of appreciation expressed by Dr. Pettit.

The motion was put and unanimously carried by a rising vote.

As there was no further business to come before the meeting, on motion of Dr. James H. Stowell, the Society then adjourned, to meet in Chicago, in 1903.

E. W. Weis, Secretary.

#### STEAMBOAT EXCURSION.

At 2 p. m. Thursday, after the final adjournment of the Society, the remaining members accepted the cordial invitation of Col. S. P. Bartlett, of the Illinois State Fish Commission, to accompany him on the handsome steamer "Illinois," to Hannibal, Mo., and return to Quincy.

### Marriages, Deaths and Changes of Address.

#### MARRIAGES.

Charles Reed, M. D., of Chicago and Miss Ethelyn Eaton of Beloit, Wis. Dec. 2.

Edw. Engleton Moore and Miss Ida M. Morley, Chicago, December 13, 1902.  
Walter Walden and Miss Albertine Wilhelm, Chicago, December 3, 1902.

#### DEATHS.

Toler, Benj. C., Astoria, Nov. 30; aged 74.  
Stayner, Wm. H., Chicago, Dec. 3; aged 42.  
Lenox, Fred, Chicago, Dec. 11.  
Landis, Edmund M., Chicago, Dec. 14, aged 56.  
Ring, John, Chicago, Dec. 17, aged 74.  
Rigg, Willis, Mt. Pulaski, July 9, aged 46.  
Venn, Ferdinand, Chicago, Dec. 15, aged 32.  
Millard, L. R., Thackery, Nov. 19, aged 80.  
Sprague, C. C., Hull, Nov. 19, aged 67.

#### CHANGES OF ADDRESS.

##### CHANGES IN CHICAGO.

Bishop, Arthur M., 85 Rush st., to Virginia Hotel.  
Daniels, Ralph, St. Luke's Hospital to ———  
Hollister, J. E., St. Luke's Hospital to 4643 Woodlawn ave.  
Place, F. R., 18 Bellevue Place to 343 Chestnut st.  
Prendergast, R., 869 N. Park ave., to 521 Belden ave.  
Rhodes, J. E., 36 Washington st., to 100 State st.  
Simmons, G. H., 63 Market st., to 103 Dearborn st.  
Stamm, J. C., 207 B. Island ave., to 2097 W. 12 st.  
Stanton, S. C., 7 Cedar st., to 1040 Sheridan Rd.

##### CHANGES FROM CHICAGO.

Boone, J. C., 1076 Millard ave., to Wickliffe, Ky.  
Higgins, A. E., 35 Fifth ave., moved left no address.  
Wing, Elbert, to Orterville, Mass.  
Helwig, Emma, to Berlin, Germany.  
Rudis-Jicinsky, J., to Cedar Rapids, Ia.

##### CHANGES TO CHICAGO.

Freer, Otto T. ——— to 36 Washington st.  
Hay, Albert H., from Europe to ———  
Norris, A. L., Farmer City to 5002 Washington ave.

##### CHANGES FROM ILLINOIS.

Allen, J. R., Custer to Arkansas.  
Campbell, J. Y., Paxton to Rochester, Ind.  
DeGraff, E. B., Rushville to Davenport, Iowa.  
Epler, J. W., Springfield to Tabor, Iowa.  
Epler, J. Crum, Virginia to Pueblo, Col.  
Epler, Ernst G., Jacksonville to Texarkana, Ark.  
Igov, Chas. W., Grove City to Ohio.  
Kelly, M. T., Springfield to St. Louis, Mo.  
Parke, Chas. T., Bloomington to Louisville, Ky.  
Rooney, A. F., Quincy to Ann Arbor, Mich.  
Scherrer, E. A., E. St. Louis to Denver, Col.  
Podstata, V., Hospital to Lake Geneva, Wis.

##### CHANGES TO ILLINOIS.

Clausius, M. F., Ft. Grant, Ariz. to Palatine.

##### CHANGES IN ILLINOIS.

Bratton, W. D., to Vienna.  
Brittin, Ernest, to Pawnee.  
Cooper, C. C., to Havana.  
Curtis, L. C., Mt. Pulaski to Elkhart.  
Fletcher, Frank E., Elkhart to Chatham.  
Hart, S. P., Waverly to Auburn.  
Kerr, E. D., Brunswick to Shelbyville.  
Koontz, C. J. ——— to Beardstown.  
McMeen, J. M., ——— to Danville.  
Oyler, H. R., Mt. Pulaski to Lincoln.  
Brandon, J. D., to Hettick.

# The Illinois Medical Journal.

The Official Organ of the State Medical Society.

EDITOR—George N. Kreider, A. M., M. D., Springfield.

Official Reporters of Affiliated Societies—

## COUNTY SOCIETIES.

Adams County—J. A. Koch, M. D., Quincy.  
Alexander County—J. T. Walsh, M. D., Cairo.  
Bureau County—H. E. Owens, M. D., Princeton.  
Bond County—W. T. Easley, Greenville.  
Calhoun County—T. O. Hardesty, M. D., Kampsville.  
Carroll County—H. S. Metcalf, M. D., Mt. Carroll.  
Cass County—J. A. McGee, M. D., Virginia.  
Champaign County—A. S. Wall, M. D., Champaign.  
Christian County—W. T. Bridges, M. D., Stonington.  
Clay County—Warren Eugene Burgett, M. D., Louisville.  
Crawford County—E. M. Cooley, M. D., Oblong.  
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Johnson County—J. E. McCall, M. D., Vienna.  
Kankakee County—J. A. Brown, M. D., Kankakee.  
Kendall County—R. A. McClelland, M. D., Yorkville.  
La Salle County—W. A. Pike, M. D., Ottawa.  
Lake County—A. G. Haven, M. D., Lake Forest.  
Lee County—E. S. Murphy, M. D., Dixon.  
Livingston County—Jno. Ross, M. D., Pontiac.

## DISTRICT SOCIETIES.

Aesculapian—H. McKennan, M. D., Paris.  
Brainerd District—J. L. Lowrie, M. D., Lincoln.  
Central Illinois—F. J. Eberspacher, M. D., Pana.  
Galva District—C. W. Hall, M. D., Kewanee.  
Fox River Valley (Kane and McHenry Counties)—F. H. Jenks, M. D., Aurora.  
Military Tract—C. B. Horrell, M. D., Galesburg.  
North Central—Geo. A. Dicus, M. D., Streator.  
Southern Illinois—E. E. Fyke, M. D., Olney.  
Tri-County—Leroy Jones, M. D., Hoopeston.  
Western Illinois—H. A. Chapin, M. D., Whitehall.

## URBAN SOCIETIES, EX CHICAGO.

Alton Medical Society—Geo. E. Wilkinson, M. D.  
AuxPlaines Medical—W. R. Livingston, M. D., Maywood.  
Decatur Medical—Lynn M. Barnes, M. D.  
East St. Louis—C. W. Lillie, M. D.  
Jacksonville Physician's Club—D. W. Reid, M. D.

All communications should be addressed to the Editor, 522 Capitol Ave., Springfield, Illinois.

The Society does not assume responsibility for any statements or opinions published in the JOURNAL.

The JOURNAL is published monthly. The subscription price is \$3.00 per annum in advance. The JOURNAL is furnished free to the members of the Society.

Entered at the postoffice in Springfield as second class matter.

Peoria Medical—C. U. Collins, M. D.  
McDonough County—R. E. Lewis, M. D., Macomb.  
McLean County—E. S. Reedy, M. D., Bloomington.  
Macoupin Co.—J. Palmer Matthews, M. D., Carlinville.  
Marion County—E. E. Fyke, M. D., Centralia.  
Marshall County—W. G. DeFour, M. D., Speer.  
Massac County—C. E. Trovillion, M. D., Metropolis.  
Mercer County—A. N. Mackey, M. D., Aledo.  
Montgomery County—J. M. Trigg, M. D., Farmersville.  
Morgan County—T. A. Wakely, M. D., Jacksonville.  
Knox County—G. S. Brown, M. D., Galesburg.  
Ogle County—H. A. Mix, M. D., Oregon.  
Perry County—J. W. Smith, M. D., Pinckneyville.  
Pike County—R. H. Main, M. D., Barry.  
Pope County—W. S. Dixon, M. D., Rosebud.  
Pulaski County—Chas. J. Boswell, M. D., Beechwood.  
Randolph County—H. C. Adderly, M. D., Chester.  
Richlan County—M. E. Poland, M. D., Olney.  
Rock Island County—G. L. Eyster, M. D., Rock Island.  
Saline County—J. R. Baker, M. D., Harrisburg.  
Sangamon County—P. L. Taylor, M. D., Springfield.  
Schuyler County—A. W. Ball, M. D., Rushville.  
Scott County—J. P. Campbell, M. D., Winchester.  
Shelby County—A. G. Mizell, M. D., Shelbyville.  
Stark County—M. T. Ward, M. D., Toulon.  
Stephenson County—R. J. Burns, M. D., Freeport.  
St. Clair County—B. Portuondo, M. D., Belleville.  
Tazewell County—C. G. Muehlman, M. D., Pekin.  
Union County—T. Lee Agnew, M. D., Anna.  
Vermilion County—E. E. Clark, M. D., Danville.  
Wabash County—J. B. Maxwell, M. D., Mt. Carmel.  
Warren County—W. H. Wells, M. D., Monmouth.  
Whiteside County—P. F. Furdue, M. D., Lyndon.  
White County—W. A. Steele, M. D., Carmi.  
Will County—Herbert S. Worthley, M. D., Joliet.  
Williamson County—G. W. Evans, M. D., Marion.  
Winnebago County—S. R. Catlin, M. D., Rockford.

## CHICAGO SOCIETIES.

Academy of Medicine—J. G. Kiernan, M. D.  
Gynæcological—R. W. Holmes, M. D.,  
Medical Society—F. X. Walls, M. D.  
Medico Legal—N. S. Davis, Jr, M. D.  
Neurological—C. H. Lodor, M. D.  
North Shore—Geo. E. Baxter, M. D.  
Orthopedic—Edwin W. Ryerson, M. D.  
Pathological—Geo. H. Weaver, M. D.  
Pediatric—Emma M. Moore, M. D.  
Physician's Club—L. H. Mettler, M. D.  
Laryngological and Climatological—J. E. Rhodes, M. D.  
Southwestern—Thos. J. McGonagle, M. D.

JANUARY 1903.

## OTHER STATE SOCIETIES—CALIFORNIA.

Last month we noticed that our neighboring state, Michigan, had revised its constitution and had commenced the publication of a monthly journal to take the place of the annual volume of transactions which has evidently had its day and must eventually be superseded by some form of monthly publication in every state having a medical organization.

It is still a far cry from Michigan to California, the next state to revise its constitution and take up the journal idea, but how much farther was it in 1856 when the California society was organized. Only those of us whose memories run back before the completion of the first transcontinental railway can appreciate the transformation which has brought the two states within four days' travel of each other. For



four years after its organization the California society held meetings, but for ten years—1860-1870—no meetings were held, doubtless because of the unrest resulting from the civil war. Since the latter year meetings have been held and much good has been accomplished. Early in the '70's a law was passed through the efforts of the profession in that state which was one of the first if not the first modern law regulating the practice of medicine in America.

Recently (1901) the California State Society succeeded in passing a new law which is said to be a good one. It creates a new and united Board of Medical Examiners, consisting of nine members, five of whom shall be *elected* by the regular society, two by the homeopathic society and two by the eclectic society. This law repeals the former law which placed the power of regulating the practice of medicine in the hands of three boards, a regular, homeopathic and eclectic. Chairman F. B. Carpenter of the Legislative Committee in reporting to the society said in part: "I wish to say in this matter that I have never until now realized what a power in the state is the medical profession. They have but to present a united front, to stand together, and if their demand is just, the people and the state will grant it. We have done what we should but have been tardy in doing it since nearly all of the larger states (except Illinois) have long ago placed such laws on their statute books." The law was ignored by the late executive Gage and allowed to become effective without his signature. He evidently did not dare to veto it. Such an insult to the profession would not be possible now since the present Governor is a learned physician.

Evidently a law regulating the practice of medicine is a great necessity in California since there are more medical men to the

population in that state than in any other in the Union. The census of 1900 places California the 2d in area, the 18th in population and 9th in the number of physicians. There are actually 4,403 physicians in the state, or one to every 337 inhabitants. In the city of Los Angeles one citizen in every 244 is a doctor of medicine, a density of medical men certainly as great as that of colonels in Kentucky. Not only are there many practitioners but an unusually large number of charlatans so that regulation is very necessary.

At the meeting in April, 1902, the society after thirty-two years of existence found itself numbering less than 400 members. In 1901 there were eleven fewer members than in 1900. Evidently some new move was necessary to hold and increase the membership. Probably nothing appeared so promising as journalizing the transactions. The first number appeared in November and is before us. The editor is Secretary Geo. H. Evans of San Francisco, and we believe he is the man for the place. That he is outspoken and ethical would appear from the language of his editorials announcing the policy of the journal while under his editorial charge. He says: The advertising pages of the journal will be limited in number and will be open only to advertising matter which complies with the strictly ethical standard that is so well understood by all yet so frequently forgotten—when there is a financial reason to forget. The journal will not publish, for any consideration, matter of the "reading notice sort," nor will it permit any "original article" infected with the bacillus of this disease to appear in its pages knowingly or willingly. It will be the partisan of no one and nothing, save only and always an energetic partisan for honest, legitimate, ethical practice of the regular profession, for truth and

right, and, first, last and all the time, for organization, and again organization, of the regular profession of California into a united body—the State Society. Brave, earnest words, brother. Keep to this high standard and we feel sure your colleagues will sustain you. In another place he says he will either edit a clean journal or “go broke” a trying. Well there will be no need to impoverish yourself. There are many honorable men conducting houses which cater to the medical profession who are willing to support decent journals and they are sure to find out the journalistic hold ups sooner or later. We have said before and now repeat that if the journals directly representing the profession are made decent and clean there will soon be little room for journals of an inferior class. We are pleased to see in the Journal that the State Society at its last meeting was outspoken in its declarations regarding the political criminals who have been hiding or attempting to hide the fact that the plague exists in San Francisco. Strong resolutions of condemnation were passed and we hope Gov. Pardee will see that a truthful statement is promulgated and proper steps taken to banish the disease. In this issue of the Journal appears the new constitution and by-laws built on the pattern constructed by the able committee of the A. M. A. While resembling the model it is in its details quite different from it. This corresponds to the view we have held since the beginning of this movement, viz., that it is impossible to formulate a constitution which will be usable in every state in the Union. Local conditions require variation in the manner of doing things but this need not occasion a very great deviation from the general principle which is to thoroughly organize by counties, have the county societies represented according to their membership in the

business branch of the State Society and put the scientific work in the hands of section officers or committees who shall be responsible for the success of this part of the work. In California the by-laws provide that the revenue for meeting current and other expenses shall be raised as follows: Each county medical society in affiliation shall be assessed not less than one dollar per member annually, or such further sum not to exceed five dollars per member, as may be assessed annually by the Board of Trustees, etc., etc.

The price of the journal is fixed at three dollars a year. We greet the infant publication and trust that the State Society of California and its journal may flourish and grow together and work wonders in the golden state.

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#### UNORGANIZED COUNTIES.

The remarkable progress of the organization of the profession in Illinois is shown by the list of unorganized counties printed below. Three years ago the organized county was the exception and not the rule. To-day so few counties are not organized that a short list includes them all. We hope that the publication of this list will stimulate the brethren in these counties to action and result in a perfected organization by the time of the next annual meeting. Some of the counties given probably have an organization but we can get no report from them and are therefore compelled to place them in the list. We believe all of the counties not organized are represented by one or more members in one of the ten recognized district societies but this is hardly satisfactory either for the county or the State Society. Our state government is so constituted that citizens in every walk of life are most influential through their local or county organizations. We are acquainted

with the condition of affairs in some of these counties and have the following suggestions to make. First: Putnam and Hardin counties have such a small population and so few physicians that it would probably be desirable to have the members attend the meetings of one of the neighboring counties. Second: Logan and Menard counties have been represented for many years in the Brainerd District Society and we suggest that that be the representative society for the two counties mentioned. Third: Ford and Iroquois counties have been united for several years and will probably desire to continue this alliance. Mason county is taking steps to organize. Madison county is also moving in this direction. Clinton county probably has an organization, but fails to make any reports.

The unorganized counties and their census (1900) population are.

Name.	Population.	No. Physicians.
Boone .....	15,791.	24
DeKalb .....	31,756.	57
DuPage .....	28,196.	47
Woodford .....	21,822.	26
Iroquois .....	38,014.	58
Ford .....	18,359.	28
Putnam .....	4,746.	8
Logan .....	28,680.	62
Menard .....	14,336.	21
Brown .....	11,557.	22
Mason .....	17,491.	34
Piatt .....	17,706.	41
Moultrie .....	15,224.	26
Edgar .....	28,273.	46
Coles .....	34,146.	66
Clark .....	24,033.	23
Cumberland .....	16,124.	26
Fayette .....	28,065.	38
Effingham .....	20,465.	43
Jasper .....	20,160.	26
Lawrence .....	16,523.	30
Wayne .....	27,626.	39
Jefferson .....	28,133.	42
Hamilton .....	20,197.	31
Hardin .....	7,448.	15
Monroe .....	13,847.	19
Clinton .....	19,824.	25
Madison .....	64,694.	102

#### ETHICS OF THE LEGAL AND MEDICAL PROFESSIONS OF ILLINOIS.

The legal profession sometimes takes summary steps to purge itself of unworthy members. When the decree of the courts is en-

tered in these cases it is final. We do not hear any cry of the invasion of vested rights, a violation of the constitution or of professional jealousy. No appeal is taken because there is no authority to which the offender can appeal. He is effectually squelched.

With this fact before us it seems strange that it is always difficult for the medical profession to get rid of the numerous rascals who use the cloak of an honorable body of men to rob helpless invalids and the mentally defective. The dishonest attorney may use his position to separate wife from husband by means of divorce. The conscienceless physician too often separates wife from husband permanently by means of a criminal abortion. If the case ever comes to trial the principal witnesses lie—one in the cemetery. Who ever heard of the conviction of such an offender? How many licenses to practice medicine have been revoked in Illinois for unprofessional and dishonorable conduct in the past twenty-five years and what has been the attitude of the courts in these cases. The courts seem to take delight in affording loopholes through which the offenders escape. Is there not some way by which we may bring the legal profession to take a different attitude in these matters. May we not appeal to them to take the same stand with regard to great offenders against our standard of morals as they do when their rules of ethics are violated. The case of a dishonest attorney was recently disposed of by the Supreme Court at Springfield and the man disbarred. He probably deserved his sentence. If he deserved punishment how much more do scores of medical frauds deserve disbarment. and how long must we wait until summary action on them will be permitted. We give the facts of this legal case in brief, taken from the press report.



### Supreme Court Rules Against Attorney Who Advertised.

Springfield, Ill., Dec. 16.—The rule of the Cook County Circuit Court is made absolute by the Supreme Court in the disbarment of Attorney William C. Smith of Chicago. Smith admitted inserting the following advertisement in a Chicago newspaper:

Loyal, wealthy atty. guarantees family freedom in a month; no advance costs; witnesses quietly volunteered. K 333, Tribune office.

The court, in passing upon the case, says: "We are of the opinion that the admitted facts clearly show a lack of good moral character and such unfitness for the practice of law that the rule must be absolute."

### HODGKIN'S DISEASE.

Within recent years a marked disposition has been evident, to attribute to tuberculosis, certain chronic cases of enlargement of lymph glands, long eponymic from their first description by Hodgkin. There have been many extenuating factors connected with this course of events. The glands first involved are usually those in the cervical region; the symptoms of the disorder indicate a constitutional affection; many cases have terminated in tuberculosis; the specific changes caused by the bacilli of tuberculosis have frequently been found in some of the glands and there has been the ever-present need of some definite etiology. The clinical features of anaemia, fever and a fatal cachexia point to an infection. For these reasons but little opposition arose to the claims of numerous observers that the disease represented an exceptional form of tuberculous lymphadenitis and this view was the more acceptable for the known ability of the tubercle bacillus to excite a proliferation of tissue.

That the process is not a simple hyperplasia as has been supposed is shown by the histological examination of the glands of eight cases by Dorothy M. Reed. (1) Seven of the cases occurred in 132 boys under

the age of 17 and 2 of these were only 5 years of age. In all cases but one the primary enlargement appeared in the cervical region; in the exception, the first nodule was noted in the episternal notch. The enlarged glands were never painful; in all cases there was an irregular fever. In five of the cases tuberculin was employed without any reaction resulting. Complete removal of the enlarged glands from a number of the patients was followed by a recurrence of the growths. In three of the cases examined post mortem, lymphomatous nodules were found in the spleen; in two, they were also present in the liver and in all three the cervical, mediastinal, bronchial and abdominal glands participated in the enlargement.

The changes in the glands from the 8 cases examined by Reed constitute the most important phase of the report and led to the conclusion that "tuberculosis has no direct relation to the subject." On the other hand it is conceded that the process is essentially a chronic inflammation and sufficiently characteristic to form a "specific histological picture." Great numbers of eosinophilous cells were found, identical with the eosinophiles of the blood, evidently emigrated from the blood vessels in response to some chemotactic substance in the glands. Large giant cells formed by the proliferation of endothelial cells and differing from the giant cells of tuberculosis were found as well as numerous plasma cells. Early in the process many lymphocytes appeared and in glands from cases in the later stages, the new tissue had become converted into fibrous connective tissue which was very abundant.

The evidence in this report upon Hodgkin's disease of a chronic infection is quite conclusive; it indicates that especial care should be used in the diagnosis of cases of chronic progressive enlargement of the lymph

(1) Johns Hopkins Hospital Reports, 1902. X, 132

glands, on the one hand from tumor growth and lymphatic leukaemia, on the other, from tuberculous. It also shows the need of further investigation of Hodgkin's disease to determine its cause as well as researches with the toxins produced by the bacillus of tuberculous to ascertain the changes they may provoke.

#### OFFICIAL REPORTERS.

At this period of the year when many societies are making changes in their officers, it may not be amiss to make some suggestions regarding the duties of the officer, usually the secretary, who makes reports of the meetings to the Journal. We feel more at liberty to do this since a number of these officers have written us asking as to the best way to report. We wish here to thankfully acknowledge the excellent work done in the past and solicit a continuance of the same in the future. First then the report should be written on one side of the sheet and should include the exact time and place of meeting, the officer presiding and the number present. The names of those present may be very properly given when reporting the smaller societies. Of course this is not expected of the societies in larger cities since our columns would soon be overfilled if the names of those attending the Chicago, Cook County, Medical Society for instance were printed. In every report the names and addresses of new members and the names of members deceased or removed since the last report, should be given. The society will in this manner be able to keep an official record of the membership and the officers and committeemen of the State Society be able at all times to communicate with every member of constituent societies. Likewise all official business should be reported in full such as reports of committees, announcement of committees, the voting of funds, etc. The titles

of all papers read should be given and usually an abstract should follow, the length or brevity of this abstract to be determined by the value and originality of the paper. This same rule should be applied to the discussions. Outside of the immediate value of the papers and discussions there is a certain historical value in the picture of medical practice at this time which is presented. Papers of unusual interest may be sent to the Journal for publication. Every paper read before a local society should no doubt have a place in the Journal, but owing to our poverty this can not be done at this time. In place of this we will gladly publish abstracts of all papers. Finally we would counsel brevity in non-essentials. It is not necessary to report that "no further business appearing the society adjourned." The single word "adjourned" is sufficient. Again brevity is desirable in recording the nomination and election of officers. It is hardly necessary to record that "Dr. A. was nominated for the office of President by Dr. B. and the nomination seconded by Dr. C. There being no further nominations Dr. E. moved and Dr. F. seconded the motion that the nominations be closed and the Secretary be instructed to cast the ballot of the Society for Dr. A. etc., etc." It is sufficient to say that Dr. A. was unanimously elected President. Brevity and conciseness should be the watchword here as in all other affairs of life. It is the distinguishing characteristic of our strenuous American existence. In continuance of this brevity and since all persons connected with our societies are understood to be titled physicians, we advise leaving off titles in making society reports. Eight or ten valuable pages will be saved in the course of the year by leaving off the unnecessary Dr. or M. D.

Finally we will express the hope that each society will compensate its secretary in some

substantial manner for his labor in attending to its business. This compensation can never be large enough to pay for the service rendered but should be given to show appreciation of the devotion of the officer, and as a stimulus to active effort.

We hope these suggestions will be accepted in the same spirit in which they are given and that the official reporters will continue to make the society columns more than ever one of the leading features of the Journal.

James B. Herrick has been appointed to the Department of Internal Medicine and John Edwin Rhodes to the Department of Laryngology in St. Mary's of Nazareth, the new hospital at 545 North Leavitt st.

## Correspondence.

### DR. STARKEL MISREPRESENTED.

*To whom it may concern—*

During the month of November there appeared in several publications, an advertisement with my name attached. I desire to state that this is an imposition and that my name has been used without my authority.

Yours very truly,

Chas. H. Starkel.

Belleville, Ill., Dec. 4, 1902.

### CAN LAWS REGULATING THE PRACTICE OF MEDICINE BE ENFORCED?

To the Editor: I deplore as you do the freedom allowed by the laws of Illinois to vagabond physicians, to mountebanks of all sorts, to zealous fanatics with a mission to heal, to adventurers vending panaceas and all the classes of charlatans whose impositions are so shameless—but I believe it impossible to effect their suppression in the legislature.

The general unwillingness to confer privileges to a class unless that class be numerically large enough to turn the scale in an election is manifest. We have importuned for a quarter of a century. Were we opulent

or in numbers 30,000 we could demand instead of petitioning to no purpose.

Your representatives in Springfield, say to us, "the lawyers, the clergymen, the teachers ask no restriction. Why shall we invest you with questionable privilege." "Those you regard with most contempt have been trained in the same colleges as the complainants. We cannot enforce by law the ethics of your profession." You know how uniformly the courts turn us down. It is in vain that we ask the arrest of these pretenders.

We are more plagued now than 30 years ago and by apostates instead of ignorant wanderers.

The state is ready to enforce all recommendations of the Board relating to quarantine, general hygiene, control of infectious diseases but is deaf and incapable were it not deaf of revoking a franchise granted under a diploma except for gross misconduct. It will not interpret advertising and boasting as misconduct. We are helpless against them except as we can prove by our work and superiority.

Unfortunately a large number of our people are yet under the spell of conjurers, fetishism mysticism and devilry and prefer always some back-stairs method to intelligent efforts in their behalf by disciplined and trained and approved skill. We must be patient with them and try to dispel their blindness and readiness to encourage secrecy. You will learn when you are older if you haven't yet learned that clearness of view and soundness of understanding are not gifts or acquisition of the multitude.

Very truly,

J. N. Randall.

Decatur, Ill.

## State Items.

The twenty institutions in Chicago where homeless and orphan children are cared for, many of them known as "baby farms" will hereafter be under the supervision of the city board of health. An effort will probably be made to have all institutions of this character



in the state inspected by one of the state boards.

St. Charles Hospital, Aurora, was opened Nov. 25, 1902. It is under the charge of the Franciscan sisters of Joliet.

A home for women just out of the hospitals has been opened on West Adams street, Chicago.

Augustana Hospital, Chicago is now free of debt and plans are being made for building an addition. Dr. Ochsner will be the head of a board of surgeons.

Mrs. Rosa Etzler of Peoria, who was engaged in selling "beauty remedies" in Pekin has been arrested, charged with the death of Mrs. Hattie Hart.

Judge Gest in the Rock Island Circuit Court this morning instructed the jury to return a verdict of not guilty in the case of Dr. William Sinsibaugh for \$50,000 against the Fraternal Tribunes, a beneficiary order. The plaintiff alleged he was permanently disabled in the initiation ceremony. The court held that the plaintiff was a willing participant in the ceremony and that there was no intention on the part of those associated with him to injure him.

Dr. Henry Wuerzinger of Chicago, has asked for his liberty, claiming that since he has been confined to the penitentiary his punishment has been changed and he has been recommitted upon another charge. Dr. Wuerzinger was sent to the penitentiary on March 27, 1900, for bigamy, and later, it is claimed, he was sentenced on another cause. Wuerzinger was convicted of having four wives and later, it was claimed, another wife of his was found.

Although as yet no overtures have been made to any one, to succeed Jacques Loeb at the Chicago University. Among those considered are: Prof. Povalow, a great Russian specialist of St. Petersburg; G. N. Stewart, professor of physiology at Western Reserve university, whose text book is used at Chicago and who lectured at the university two weeks ago before the Physiology club; W. M. Howell of John Hopkins university, who has carried on researches similar to those of Dr. Loeb; and Dr. Sherrington, a noted English scientist. Another specialist whom the university is trying to secure is Prof. Moll of John Hopkins, who, if he comes, will take the chair of anatomy, Dr. Barker giving his attention to pathology.

Dr. Loeb will leave for California early in January.

The State Barbers' Protective association, begun energetic work in behalf of its bill for a state barber shop law.

The sterilization of razors, rinsing of mugs, use of clean towels, are among the measures made compulsory in the bill to stop the spread of contagion. Better workmanship, better wages, and almost absolute safety to their patrons are declared to be obtainable should the new methods prevail. The association will intrust the introduction of the newly completed bill to Representative C. H. Backus of Hampshire. It is entitled

"An act to establish a board of examination for barbers and the licensing and regulating the occupation of all barbers in this state and

to prevent the spread of contagious diseases," is the way the preamble of the bill reads. The board of examiners is to be composed of three qualified barbers, to be appointed by the governor, and it is planned to hold public examinations in four different cities of the state each year. Persons now engaged in the occupation of a barber will not have to take the examination but will be compelled to obtain a certificate from the board and pay a license fee of \$1 a year.

The Visiting Nurses' association of Chicago has decided to organize a permanent tuberculosis crusade committee. This committee will consist of medical and lay members representing various public societies, and it will disseminate literature, extend hospital and sanitarium facilities, and otherwise provide care for those suffering from the disease. Wherever public steps of this kind have been taken, the death rate has decreased 20 per cent.

## OBITUARY.

John L. White, M. D.

The death of Dr. John L. White, of Bloomington, Ill., which occurred May 13th, 1902, just on the eve of the annual meeting of the Illinois State Medical Society at Quincy, deprived that organization of another of its ex-presidents and one of the fathers of the profession in Central Illinois.

Dr. White was one of the ablest, most widely known and prosperous physicians of the State. A man of commanding presence, dignified and impressive demeanor, a judicial cast of mind and solid intellectual as well as social attainments, he had a marked influence on the community in which he lived. Kindly and courteous, as well as sympathetic in manner he won the good will and confidence of high and low alike. He was the soul of courtesy and consideration in his relations with his professional brethren, and the members of the McLean County Medical Society attended his funeral in a body.

Dr. White was of historic Massachusetts stock, being the son of Dr. John White and Lucy (Howe) White. His father was a physician of prominence in Westminister, Worcester County, Mass., being a graduate of Brown university, Rhode Island. Subsequently he removed to Watertown, N. Y., where he died in 1868. The White family was originally Scotch-Irish and emigrated to Massachusetts soon after the historic voyage of the Mayflower.

Our subject read medicine with his father in Westminister, and subsequently received a thorough education both at Dartmouth college and Harvard university, graduating from the medical department of the latter in 1854. While a medical student he served as an interne in the Massachusetts General hospital, and in the fall succeeding his graduation migrated to the West and located at Jerseyville, Ill.

Dr. White remained at the latter place until 1859, when he removed to Memphis. Upon the

outbreak of the Civil war, however, he returned to Jerseyville. While he did not go to the front in any professional capacity, as surgeon of the board of enrollment of the tenth congressional district, his services at home were held in high esteem. He continued practice at Jerseyville until 1870, when he settled in Bloomington, where for nearly thirty years his reputation and popularity, both as a man and a physician, has continued to steadily increase. He

He was also connected with the I. O. O. F. In his religious tenets he was an Episcopalian.

On February 10, 1857, Dr. White was married to Miss Hattie Hawley, of Jerseyville, Ill. They have two living children.

**Samuel J. Jones, M. D., LL. D.**

Dr. S. J. Jones, of Chicago, who departed this life Oct. 4th, 1901, was for six consecutive years (1881 to 1886) Secretary of the Illinois



JOHN L. WHITE, M. D.

has served as president of the Illinois State Medical Society (1878) and has otherwise been honored by his professional confreres.

Dr. White was a member of the leading medical societies. Of the secret orders he perhaps took the most interest and achieved the most prominence in the affairs of the Masonic fraternity. He was a 32d degree Mason and was honored with the position of grand commander of the Grand Commandery of the State.

State Medical Society, and for many years previously had taken a very active personal interest in its welfare. He was a man of fine educational acquirements, suave and diplomatic in manner, and calculated to grace with the acquirements of culture and affability anybody with which he became associated. His association with men and affairs had been active and extensive, and a wide acquaintanceship thereby secured made him not only an admir-

able companion but a man of influence in and out of his professional sphere. As a professional man and practitioner in his special field of oculist and aurist he took high rank. He was a lover of general scientific literature, and took much interest in the advancement of science in all lines.

Dr. Jones was born March 22, 1836, at Bainbridge, Pennsylvania; graduated from Dickinson college, Carlisle, with the degree of A. B., in 1857, and received therefrom the degree of A. M. in 1860, and that of LL. D. in 1884; graduated in medicine from the University of Pennsylvania in 1860. In December of the last named year he received the appointment of assistant surgeon, United States Navy, and was promoted to the rank of surgeon in 1863. He remained in the service until 1868, when he resigned to commence the practice of his profession in Chicago.

Dr. Jones was a member of the American Medical association since 1868. In that year he was delegated to the meetings of the medical associations of Europe, and at Dresden, in September of that year, participated in organizing the first Otological congress ever held. In 1870, he was again delegated from the American Medical association to the meetings of the foreign societies, and at that time spent some months abroad in medical research and investigation; in 1881, represented the same association and the American Academy of Medicine in the Seventh International Medical congress, London. He was a member of the Chicago Medical Society; of the Chicago Ophthalmological and Otological Society; of the American Otological Society; of the Illinois State Medical Society, and one of its delegates to the Centennial International Medical congress, Philadelphia, 1876; of the American Academy of Medicine, vice-president in 1887, president in 1889; of the Ninth International Medical congress, Washington, D. C., 1887, president of the section on otology, and ex-officio member of the executive committee; of the Chicago Academy of Sciences, was its vice-president, and was a member of its board of trustees; one of the founders of the Chicago Folk-Lore Society; of the Western Association of the Alumni of the University of Pennsylvania, president in 1894 and 1895; president of Illinois, Alpha Chapter of the Phi Beta Kappa, the oldest Greek-letter society in the United States, founded in 1776; whose membership has always been restricted, and conferred as a recognition of scholarship.

Dr. Jones was professor of Ophthalmology and otology in Northwestern University Medical school, Chicago, from 1870 to 1897; established the eye and ear department of St. Luke's hospital, in 1869, of Mercy hospital and South Side dispensary in 1870, and had charge of all of them until 1880. Was surgeon to the eye and ear department of St. Luke's hospital. Was on the medical staff of the Illinois State Charitable Eye and Ear infirmary, 1874-82, and surgeon to the Illinois Naval Reserve, 1894-95. He was president of the National Pure Food association.

Dr. Jones edited the Chicago Medical Journal and Examiner from 1887-92, and outside of articles in this journal made reports of surgical cases to the American Journal of the Medical

Sciences; papers and reports on ophthalmology and otology to the Illinois State Medical Society, American Medical association, and to the Centennial International Medical congress. His writings being both clear and practical.

#### Katherine Miller, A. M. M. D.

On August 1st, 1901, at her home in Lincoln, Illinois, occurred the death of Dr. Katherine Miller, for many years a most active member, as well as constant attendant on the meetings of, the Illinois State Medical Society.

Dr. Miller was one of the most popular, able and thoroughly educated practitioners of Central Illinois. She was a native of New Hampshire, but lived in Lincoln nearly all her life. She graduated from the Lincoln high school in 1873 and from the Lincoln university in 1877, taking the Master's degree from the latter in 1882. She commenced her medical studies at home, and subsequently took the regular course at the Northwestern University Woman's Medical school in Chicago, from which she graduated in 1882.

Dr. Miller at once took up the practice of medicine at Lincoln. She took several post-graduate courses in Chicago and Boston, and was constantly numbered with those progressive members of her profession who never get beyond the attitude of conscientious students. The result was one of the best general practices in that portion of the State.

Dr. Miller was secretary for several years of the Brainard District Medical Society, member of the American Medical Association, and as before stated a most active and useful member of the Illinois State Society. She was medical examiner for Ladies of the Macabees, the American Legion of Honor, Royal Circle, etc.

Dr. Miller always took a very active part in educational matters, and was for some years a member of the Lincoln City board of education.

#### Dr. William Weir Hester.

At a stated meeting of the Commandery of Illinois, Loyal Legion of the United States, Sept. 25, 1902, the committee reported the following tribute of respect:

William Weir Hester was born near Charles-town, Indiana, April 18, 1835. He was about five years old when his father and mother died of malignant fever in ten days of each other. His father died first, and he remembered clearly the leave-taking when his dying mother was carried to the bedside of her dying husband. Four little boys were left. William Weir, the second son, went to live with his grandmother, Susan Hester, a widow whose husband, Mathias Hester, was scalped by the Indians in Bear Grass Creek, near Louisville, Ky., in 1791.

After six or seven years he went to make his home with his uncle, the Rev. Geo. K. Hester, of Charlestown, Indiana, where he remained until he was old enough to choose for himself the education which was to fulfill his boyhood's dreams.

At the age of eighteen he began teaching school, and taught about eighteen months with success. But the desire of his youth and the



deepest devotion of his life lay in his chosen profession; it drew him steadily away from other things, and at twenty he was studying medicine with his uncle, Dr. U. A. V. Hester, of Gosport, Indiana, for his life work.

In 1858 he took his degree at the Medical School of Louisville, Ky., and soon after began the practice of medicine in Cataract, Indiana.

In 1859 he located at Rome, Perry County, Indiana, on the Ohio River. He soon acquired by his indefatigable energy a lucrative practice, which involved hard riding over the hills of Perry County.

But the guns of Sumter stirred his soul, and without thought of consequences, like so many other noble souls in that year of our Lord, he entered the Army, and without parole served his country for three years and a half, coming out as Lieutenant Colonel of the Forty-eighth Kentucky Volunteer Mounted Infantry. He was in many engagements, raids and battles, among which was the battle of Corinth. So much had he commended himself to his superior officers as a man of military mould, that the strongest inducements were offered him to enter the Regular Army. After short consideration, however, he refused. He had chosen a profession which heals, and patriot and soldier as he continued all his life long, it was far dearer to him than that which wounds.

Immediately after his discharge from the Army he was elected Clerk of the Indiana Legislature for one term. At the close of this term of the Legislature he was called to the State Hospital for the Insane at Indianapolis as first assistant physician. Here he remained fourteen years and a half. Early in this period he had leave of absence from hospital service, and took the course in medicine at Jefferson Medical College in Philadelphia, receiving its diploma. Pursuing this course in mature years, he carried it with honor and with results which showed in the thoroughness of his professional work.

In 1879 he was called to the Southern Hospital for the Insane at Anna, Illinois, and here he served the State most successfully for eleven years longer. He withdrew in 1890 and took up the general practice of medicine in Chicago. His strong, good sense, his skill in diagnosis, his careful attention to every phase of the malady and every condition of the sick-room were giving him a place among the physicians of Chicago that would have been second to none in general practice, when the disease which proved fatal attacked him. In the past six years and a half he has undergone three operations, the third in November of last year. Up to that time his fine constitution, pure life and strong will had made it possible for him to resist the encroachments of the disease, the foundations of which were laid during his service in the Army. But the end of his valiant fight was nearer than it seemed, and on the 18th of July last he died, having been confined to his bed only nine days. He had fought a good fight with the weakness of the flesh. He had kept faith with all who trusted him as a physician or as a man. There is,

we know, laid up for such the reward which Godhood keeps for manhood preserved.

John McLean,  
Theodore H. Patterson,  
Charles F. Matteson,  
Committee.

## New Incorporations.

Certificates of incorporation were issued by Secretary of State Rose at Springfield as follows:

Salon Debeaute, Chicago; capital, \$2,500; manufacturing and selling toilet and proprietary preparations; incorporators, Arthur W. McCovney, Eli Moses, and Johan Waage.

The White Cross Visiting Nurse Association, Chicago; capital, \$2,500; to conduct hospitals; incorporators, Samuel Sherin, Susie Sherin, and Wesley M. Sherin.

Hempstead & Co., Chicago; capital, \$2,500; manufacturing and dealing in toilet, table and medicinal supplies; incorporators, Frank Hempstead, Thomas B. Lantry, and George W. Lyon, Jr.

The Illinois Licensed Embalmers' Association, Chicago; regulating wages and hours of labor; incorporators, W. W. Whitaker, H. D. Ludlow, and C. F. Drake.

The Federal Drug and Chemical Company, Chicago; capital, \$16,000; manufacturing drugs, chemicals, etc., incorporators, Nathan S. Smyser, E. J. Wilber, Jr., and A. H. Kay.

Lister Medical Institute, Chicago; capital, \$2,500; to manufacture medicines; incorporators, M. B. Marshall, Roy C. Merrick, and Adolph Raphael.

The Dr. Phillips Electric Sweat Robe Company, Chicago; capital, \$10,000; manufacturing electric appliances; incorporators, John H. Wilson, Harry Hamil, and Laura Wilson.

Pabst Chemical Company, Chicago; capital, \$2,500; to manufacture proprietary medicines; incorporators, Friedolin Pabst, Theodore Harveck, and Thomas F. Corcoran.

## Local Societies.

The Lee County Medical Society was recently organized with the following officers:

President—T. H. Stetler, Paw Paw.

Vice President—D. H. Law, Dixon.

Secretary—E. S. Murphy, Dixon.

Treasurer—C. C. Kost, Dixon.

The Cass County Medical Society met at Virginia, December 3, 1902.

Please add to your list of charter members the names of Darwin O. Gailey, Ashland; Watson W. Gailey, Ashland; Daniel Lyons, Ashland, and Florence Goff Anderson, Virginia.

Our meeting was a very interesting one, the time being given to the discussion of general business, perfecting our organization, and

getting things in shape. The outlook is very encouraging, and at next meeting we will take up the regular order of business. Out of thirty-two physicians in the county, twenty have already become members, with the promise of more. All who have become members seem to be interested, and take an active part.

J. A. McGee, Official Reporter.

The Scott County Medical Society met at Winchester, December 16, 1902, in regular session at 2 P. M. President James Miner called C. H. Dyer to the chair and read a letter from C. E. Black in reference to our society's endorsement of the proposed bill for the regulation of the practice of medicine in Illinois.

The following resolution was read by Dr. Miner, who moved its adoption:

Resolved, That the Scott County Medical Society hereby heartily approves and endorses the proposed bill for the regulation of the practice of medicine and establishing a Board of Medical Examiners in the State of Illinois.

After discussion the resolution was unanimously passed. By motion the secretary was instructed to make application to Dr. Weis, secretary of the State Medical Society, for membership therein. A paper was read by Dr. Trapp of Merritt. Topic, **A Plea for Early Diagnosis in Syphilis**.

J. P. Campbell, Official Reporter.

The Will County Medical Society held a special meeting November 26, 1902. Two very interesting papers were presented.

E. J. Higgins read a paper entitled "**When Shall We Operate for Appendicitis**." The paper showed much study of the subject and was very ably presented. The discussion brought out points of value to every member of the society.

A. J. Lennon's paper on **Cholelithiasis** was then read by the author, who showed in a masterly manner the prevalence of the disease and cited some very interesting cases.

The following committee, consisting of William Dougall, William Richards and P. G. Rulien, were appointed to try to secure a uniform fee bill.

Minnie Bowles brought up for the consideration of the society the question of **Voluntary Examination and Inspection of our School Children** at the schools by local physicians.

The next regular meeting of the society will take place January 13, 1903.

Herbert S. Worthley, Official Reporter.

The Tri-County Medical Society—Vermilion, Ford and Iroquois.

The winter meeting was held in Hoopston, December 2d. Thirty or more members were present. The meeting place was the G. A. R. Hall, and Frank M. Mason of Rossville was president.

The following doctors applied for membership: C. E. Wilkinson of Danville, J. S. Adsit of Hoopston, W. B. Williams of Cissna Park, A. W. White of Paxton, and C. V. Luke of Woodworth. All were found worthy and elected members.

A number of excellent papers were read and discussed as freely as time would allow.

But the chief feature of this meeting was a lecture on "**Curettage**," by Palmer Findley of Chicago.

This address was especially interesting and instructive by reason of the exhibition of a number of specimens shown during the address.

There were an afternoon and an evening session, with supper at the Cunningham House sandwiched between. The June meeting goes to Danville.

Leroy Jones, Official Reporter.

The Vermilion County Medical Society met Monday evening, December 8, 1902, in the city hall. Called to order by the president, H. F. Becker.

The November minutes were dispensed with on account of time.

The paper of the evening was on **Typhoid Fever and its Complications**, by Jos. Fairhall. Discussion was opened by E. A. Johnston, which became general and exceedingly valuable.

The board of censors reported favorably on the names of Francis Barton, Benj. Gleeson and S. L. Landauer, followed by their election to membership.

F. N. Cloyd of Westville presented a very interesting case of **Tachycardia** of several years' standing, in which the heart beats run from 150 to 200 and more per minute. The man works regularly in the coal mines but has to be kept under the effect of strophanthus and digitalis, which holds the pulsation at 85 per minute.

There was a report of the recent Hoopston meeting of the Tri-County Medical Society.

There being no further business the society adjourned to the January meeting.

E. E. Clark, Official Reporter.

The Rock Island County Medical Society held its first regular monthly meeting at the Harper House, Rock Island, Ill., Tuesday evening, December 9, 1902.

There was a good attendance of the membership of the society, who partook of a very delicious banquet prepared for the meeting, and seemed, to the cursory observer, to be a lot of doctors who were thoroughly interested in testing the effects of toothsome delicacies on their own alimentary organs. After a somewhat prolonged sojourn at the table, engaged in this fascinating investigation, the meeting was called to order and an impromptu and informal program was carried out.

G. G. Craig of Rock Island made a very interesting and instructive report upon the personal characteristics of Adolph Lorenz, and his methods of procedure in his operations for the cure of congenital hip dislocations. This report brought forth considerable discussion of the matter by a number of those present.

Jos. DeSilva of Rock Island reported a **fracture of the patella** treated by long lateral splints and adhesive plaster, with bony union and perfect functional result. The question was discussed by Drs. Long and Dunn.

A. M. Beal reported a fatal case of that

rather rare and peculiar necrosis **tetany** in a child of eleven years, death ensuing in about twenty-four hours after the initial symptoms. The case was discussed by Drs. Ludewig and Craig.

W. H. Ludewig of Rock Island reported a case of **malaria** with unusual features. The report was discussed by Drs. Eyster, Gardiner and Craig.

The society then spent some time in discussing the features of the **new fee bill** adopted by the Medical Union of Rock Island and Moline.

Your reporter neglected to record the fact that at the November meeting this **society appropriated the sum of twenty-five (\$25.00) to be forwarded to the Committee of the State Society on Medical Legislation.**

After a very pleasant evening spent in the discussion of professional topics, the society adjourned to meet in Rock Island on the second Tuesday in January, 1903.

Geo. L. Eyster, Official Reporter.

The **Southwestern Medical Society** was called to order December 9, 1902, by Vice President Weir at 540 W. 63d st., after the usual lunch. A business meeting was held.

The minutes of two previous meetings read and approved.

The Committee on Banquet made a report of progress. The committee was then authorized to arrange for the banquet to be held January 13, 1903, down town, and that the cost not to exceed \$2.00 per plate.

The Committee on Affiliation made its final report, a part of which was a revised constitution and by-laws.

The report was accepted.

**The motion, that we affiliate with the Chicago Medical Society of Cook County was seconded and carried.**

The revised constitution was then voted for section by section, and with the exception of two amendments was adopted. A copy of the new constitution and by-laws will be forwarded later.

Meeting then adjourned till January 13, 1903, at the banquet.

Thos. C. McGonagle, Official Reporter.

The **Marion County Medical Society** met in Centralia, Saturday, December 6. Sixteen physicians were present. An interesting program was presented.

President A. P. Kell read a paper on the **General Benefit to be Gained by Compact Organization of the Profession.** He laid stress on the responsibility of each individual to contribute to the success of the local societies. These organizations are a specific for professional bickerings and misunderstandings, and the frequent meetings of medical men with free interchange of ideas will inspire earnest work, thereby raising the standard of medical knowledge, serving to dignify the profession among its own members as well as the laity. He deprecated the indifference of public officers to proper medical legislation, citing a recent

decision of the U. S. Supreme Court in the case of a Missouri magnetic healer.

J. W. Murfin presented a paper on "**The Microscope in General Practice,**" in which the author indicated the necessity for more thorough work along this line, particularly by the older practitioners whose college training did so little to familiarize them with microscopical technique. The paper referred to the daily increasing prominence of bacteriological and pathological work, and predicted that in a few years the microscope would be regarded as essential to the conscientious physician as the clinical thermometer or stethoscope.

O. D. Deihl presented a paper on **Cystitis**, in which especial mention was made of those cases occurring from the use of unclean instruments by physicians. In the author's opinion, a majority of cases met with in general practice might have been prevented by attention to the simple details of asepsis. For treatment, the author recommends rest in bed, light diet, alkaline drinks in profusion and vesical irrigation; care being taken not to distend the bladder by the latter measure.

J. W. Armstrong reported an interesting case in the **removal of a block of wood from the skull of a young man.** The splinter, which was one-half inch square and near two inches in length, had been driven through the frontal bone when the boy was thrown from a horse. It had broken off at the surface of the skull, and its presence was not discovered until one week later. Upon its removal, a portion of his hat, together with dirt, hair and several pieces of the inner table were removed from the brain. Recovery was uneventful. An interesting feature of the case was the fact that no symptoms of brain injury were present at any time.

The society will hold its next meeting at Centralia the fourth Friday in February.

E. E. Fyke, Official Reporter.

The **Decatur Medical Society** has held several interesting meetings since I wrote you, and I shall report them briefly.

In September the society met by invitation at the home of President S. J. Bumstead and listened to a very carefully prepared paper on **Cerebral Localization** by F. M. Anderson. Refreshments were served and the discussion continued informally over cigars.

At the October meeting J. Stebbins King read a paper on **The Mosquito as a Carrier of Disease**, a subject for which his residence in the South and his military service in the Spanish war had especially fitted him.

H. C. Jones presented an interesting pathological specimen which consisted of an **intussusception of the bowel** which occurred in a four and a half months' old child. Injections of water had failed permanently to reduce it, and operation was not done because of the tender age of the patient. The case is remarkable because the child lived eight days after the attack. The specimen showed the intussusception at the ileo-caecal valve, extending into the caecum a distance of two or three inches. The appendix was partly drawn into the caecum.



The committee appointed by the president to consider what action this society should take in regard to the proposed Medical Practice Act wishes to report as follows:

The failure of the last proposed medical law to pass the State Legislature successfully was due in large part to the apathy of the medical profession and the various medical societies and the lack of organization and funds of the regular profession; on the other hand the complete organization of the opposing forces, the combinations formed by the quacks, osteopaths, mental healers, etc., the employment by them of distinguished lawyers and wily lobbyists, the free use of money for this and other purposes resulted in the development of large opposition or at least apathetic support both in the State Senate and House of Representatives, and such demoralization of the bill as to prevent its passage.

The committee, led by Dr. Black, have assiduously studied and compared every medical practice act in the United States. This has required much unselfish work on the part of Dr. Black and his committee, many hours of midnight oil and many railroad trips with loss of time and money by the various members. In recognition of their services we, the members of the Decatur Medical Society,

**Resolve, That this society is heartily in accord with the Committee on Medical Legislation of the Illinois State Medical Society and unanimously approves the law proposed to be submitted to the next Legislature, and further pledges the individual efforts of its members to secure its passage.**

**Resolved further, That the treasurer be instructed to collect the sum of fifty cents from each member of this society in addition to any individual payment heretofore made, the same to be paid at once to the Legislative Committee, for securing the passage of the new law.**

H. C. Jones then presented the paper of the evening on **The Status of the Uric Acid Question.**

S. E. McClelland presented the chief paper at the December meeting upon **The Evidences of General Disease Revealed by Examination of the Eyes.** The discussion was quite general, and many cases were cited in which examination of the eyes served to clear up obscure cases.

The society will hold its second annual banquet in January, and an enjoyable time is anticipated.

Lynn M. Barnes, Official Reporter.

**The Carroll County Medical Society** met in Mt. Carroll December 9th.

The meeting was called to order by the President, J. Haller of Lanark. Minutes of the September meeting were read and approved. The following were admitted to membership: D. M. Greeley, Mt. Carroll; R. P. Wales, Mt. Carroll; R. H. Wood, Mt. Carroll; R. B. Rice, Mt. Carroll; S. P. Colehour, Mt. Carroll; H. J. Hughes, Mt. Carroll; L. H. Maloney, Savanna; I. W. McPherson, Hazelhurst.

The question of a county Fee-Table was

freely discussed, and the proposed bill with a few changes was adopted.

The Society will meet four times a year.

Henry S. Metcalf, Official Reporter.

#### **The Southern Illinois Medical Association. Report on a Case of Epilepsy.**

Synopsis of paper read at Centralia, November 6, 1902, by G. H. French, A. M., Carbon-dale, Ill.

In the beginning of this paper I should say that my relation to this disease is solely one of investigation. Four years ago, at the November meeting, H. C. Aderly brought before the meeting some intestinal parasites from a case he had at that time for identification, and suggestions as to treatment. The members of the association did not recognize them, and the president, A. M. Lee, brought them to me. I did not know them. A little investigation showed them to be new to science and they were described by your speaker and the description was published in the scientific press under the name **Gastrophilus Epilepsalis.**

In Dr. Aderly's case a thorough cleaning out of the entire canal cured the boy, though before this he had had as many as twenty spasms in twenty-four hours, and this had been kept up for four years.

Four other cases of epilepsy have been found where these parasites were a factor. One of these gave the same results as the first case. One proved to have other sources of irritation and the case was not cured by removal of the parasites. Results in the other two cases are not known.

The publication of my article called forth a great many letters from doctors and others, among which was one stating that a man had cured himself and several others by the use of **Verbena Hastata**. I also learned that a doctor had cured a very bad case with the same remedy.

Naturally this side of the investigation led to a study of the therapeutic side of the subject, and it was not long till I had a call of such a nature that I decided to try the effects of verbenin, the alkaloid of **V. Hastata**. While I was treating this case there was decided improvement; but sickness in the family led to a neglect of the epileptic and the treatment was dropped.

From the great number of applications for treatment that were made about this time a few cases were selected and experimental treatment began on the basis of finding and removing the cause and treating the nervous system. One of these is the case presented for your consideration.

Miss C., a maiden lady, age 39, had the disease since she was 7 years old. Until 20 the spells were light, but always with loss of consciousness, lasting only a few minutes. Since that time she has continued to have the "little spells," as she calls them, but has had hard spasms. These occurred once in about three weeks, though sometimes two, three or even more attacks might occur in a month and she would have a great many of the little

spells with three hard spasms during the day. Usually an attack would continue two or three days, the spells growing more severe as the years passed. There was some mental aberration. The attacks were preceded and followed by debility, irritability and many other symptoms too well known to repeat. She is well developed, has had no shock nor accident. As an attack approached constipation and general torpidity of kidneys and other organs were prominent.

In treating this case the remedies made by the Abbott Alkaloidal Co. were used. The first medicine was sent to her sister October 20, 1901, and the package contained anticonstipation granules, verbenin, hyoscyamine and menthol. The first was to be given in 4 doses and just enough to give one good passage a day. The second, two tablets at a dose, and 4 doses a day. The third one granule at a dose 4 times a day. The menthol one tablet after each meal. The others were to be taken after each meal and on going to bed.

In the next sending iron hydrocyanate was added to the prescription, a tablet after each meal, but this did not seem to improve her condition; it was replaced with iron valerianate and strychnine valerianate but after a few weeks both these were dropped. As the spasms continued the dose of verbenin was increased to 6 or 7 at a dose 4 times a day.

For a slight genital trouble gelseminum was prescribed, but afterwards replaced with cypripedin; and for a stomach weakness and as a tonic quassia and quinine arsenate were given. These changes were made March 31st, and no further changes have been made since.

Results: At first there was very little change in symptoms. The spells soon began to grow lighter with less of the jerking. At first there would be 2 spasms a day during an attack instead of 3 and the attacks occurring once in 4 to 6 weeks apart instead of several a month; with fewer of the little spells, these were finally seldom felt. On October 6 the sister writes, "Sister is now better than she has been in the past nine years. She is working hard at out of doors work and feels that a cure is sure to be perfect. She eats well, digestion is much better, sleeps very well about nine hours, bowels well, really seems to be getting well in every way." In a letter written November 1 she writes, "You would be pleased to see how well sister thinks and talks after so many years of this trouble."

Now, gentlemen, this case is not cured yet, but I see no reason why it may not be ultimately by following up the treatment here outlined.

I might say that there is a brother in the family who is also an epileptic.

The Sangamon County Medical Society met in the supervisors' room at the court house, Springfield, in regular session Monday, December 8th, at 8:30 P. M., President A. C. Brittin in the chair, B. B. Griffith acting as secretary. There were fifteen members in attendance. The meeting having been called to order, the minutes of the November meeting were read

and approved. Upon motion of G. N. Kreider, which was seconded and carried, the application of N. R. Gordon was postponed until next meeting, until information desired could be secured by the secretary. J. W. Kelly later presented a communication from N. R. Gordon furnishing the society the desired information. The motion of G. N. Kreider was reconsidered and carried. Upon motion of C. S. Nelson, which was seconded and carried, a ballot was taken upon the application of N. R. Gordon for membership in the society, which resulted in his election. The secretary reported that M. J. Kelly of Springfield had moved to St. Louis, Mo.

The amendment to the constitution proposed at the November meeting that the office of secretary-treasurer be vested in one person came up for consideration. G. N. Kreider moved its adoption. The motion prevailed. C. S. Nelson nominated P. L. Taylor for secretary-treasurer for the ensuing year. There being no further nominations, the president declared the ballot unanimous and P. L. Taylor elected. The report of the secretary for the year just closed was read and ordered placed on file. The report of the treasurer was read and ordered referred to the board of directors to be reported on at the January meeting.

It was moved and seconded that the president appoint a committee of three to solicit membership for the society in order that we might secure every eligible doctor in the county. The motion prevailed. G. N. Kreider, J. W. Kelly, C. S. Nelson were appointed as the committee. Upon motion of G. N. Kreider the president appointed a Legislative Committee consisting of J. A. Egan, J. N. Dixon and S. E. Munson. Bills from the secretary and Phillips Bros were read and ordered paid. It was moved and seconded that delinquents two years in arrears for dues be notified that they would be dropped from the membership list in thirty days unless they settled or offered some explanation. The motion prevailed. The literary program was a symposium on Chorea.

George Clements read an excellent paper on the etiology and pathology of the disease. As to the symptoms and diagnosis of chorea, O. F. Maxon stated that there was an interference with the proper performance of the motor function of the brain which is chiefly expressed by a lack of co-ordination of muscular movements, spasmodic in character with variable degrees of muscular weakness and physical disturbances. Types of the disease vary from the fidgety child to the one with continuous muscular movements. These movements usually begin in the face and arms. When in the face the eyelids or brows may be suddenly raised or lowered with various meaningless distortions of the face, sudden twisting of the neck and shrugging of the shoulders are common. As different muscles of the upper extremity are involved we get diverse movements of the hand and arm. Implications of the trunk may produce squirming or swaying movements as the patient stands or sits. The interval between spasms is at first long, gradually decreasing with time. In fatal cases the



spasms are so frequent as to prevent sleep. Headache is common and tenderness along the nerves has been observed, pain is usually absent. Aside from the muscular symptoms, the heart presents the most interesting phenomena. Typical symptoms predominating, the disease is usually easy to diagnose. When occurring early in young children it may be mistaken for congenital palsies. Hysteria may be confused with chorea.

B. B. Griffith stated that the treatment must be empirical or symptomatic. The educating of the nervous system along hygienic principles is quite essential. All irritation must be cared for, and quiet should be insisted upon. The ice pack is sometimes found useful. Most authors agree that arsenic given in increasing doses to the point of tolerance is usually efficacious, bromides greatly assist in relieving the nervousness, cimicifuga and hyoseyamine are also recommended. Narcotics should not be used. Citrate of iron and quinine are good as a tonic. Light gymnastics are also recommended in cases where the heart will stand it.

In opening the discussion M. T. Shutt expressed herself as being interested in the etiology of chorea, spoke of there being so much difference of opinion among authorities as to how great a factor rheumatism was as to a cause. Specialists in children's diseases claim for it a higher percentage than neurologists. Family heredity is frequently very marked in chorea. R. D. Berry enjoyed the papers and was inclined to the uric acid diathesis as a causative factor and considered arsenic good medication. Helen Babb thought the teaching of music to school children, especially piano lessons, was an important etiological factor in producing the disease. Estelle Paullin spoke of having used antifebrine successfully in a case. A. D. Taylor called attention to the fact that in examining the knee reflexes, relaxation was very tardy; also spoke of immobilizing the limbs under anaesthesia, by splints, from four to six days. G. N. Kreider expressed himself as thinking the disease largely a functional neurosis. J. N. Dixon said he did not know that chorea was due to rheumatism. J. W. Kelly spoke of a tramp he once saw who had been a telegraph operator, and had chorea; considered it an occupation neurosis in this case. G. C. Clements said that rheumatism is prevalent in many cases and that the negro is exempt from chorea although having a tendency to rheumatism. Neurotic predisposition is a prominent factor in etiology. O. F. Maxon thought that a definition of chorea and rheumatic diathesis would be difficult and spoke of one authority who advanced the idea that endocarditis was not a complication of rheumatism but rheumatism itself.

J. N. Dixon reported a very interesting case of **ptomaine poisoning**, which in all probability had its source in eating a piece of tainted ham. Upon further investigation he found that others who ate of the same ham also had symptoms of poisoning. R. D. Berry reported two cases of ptomaine poisoning he had seen in his experience. One of them suffered excruciatingly, not controlled by morphia.

The treasurer reported balance on hand

November 11, 1901.....	\$125 32
Dues collected in 1901 and 1902.....	118 00

Total on hand.....	\$243 32
Amount of expense for 1901 and 1902..	158 55

Balance on hand November 11, 1902. \$84 77

The average attendance at the meetings held during the last year was twenty-one. Three new members have joined the society, four have moved from the county and one died, leaving sixty-nine members in good standing.

There being no further business the society adjourned.

Percy Louis Taylor, Official Reporter.

The **Adams County Medical Society** was called to order December 8th at 1:30 P. M., by Vice President E. B. Montgomery, in the absence of President Gilliland.

Under the new constitution and by-laws the following were appointed on committees:

**Committee on Program and Scientific Work**—John A. Koch, chairman; Jos. Robbins and W. W. Williams.

**Committee on Public Health and Legislation**—L. H. A. Nickerson, chairman; H. P. Beirne and J. M. Grimes.

**Committee on Social Entertainment and Refreshments**—R. J. Christie, Jr., chairman; Henry Hart and F. E. Tull.

The secretary reported that J. F. Wilson of Bluffs, Scott county, had requested a withdrawal card from this society to join either the Scott or Morgan County Medical Society. The card was issued to him.

The following were elected to membership in the society:

Margaret Anderson, W. G. Schmidt, A. H. Schmidt, A. H. Byers, H. H. Rodefield, C. W. Pfeiffer, G. W. Burch, E. Zimmerman of Quincy; and G. A. Lightle of Plainville.

W. W. Williams gave a review of the literature on **Pregnancy following the conservative operation on the Fallopian Tubes and Ovaries**, and a report of a case.

In looking over the literature of pregnancy following conservatism I find the following that may be of interest to you: Out of a series of eighty cases treated conservatively by W. M. Polk and most of them seen at intervals varying from six months to two years after the operation, all but seven gave excellent results, and four out of the eighty bore children.

A. Martin, in a series of forty-five cases. Twenty-one of resection of the ovaries and twenty-four of operation upon the tubes—lost two, one in each group; and of the twenty women surviving the ovarian conservative operations five became pregnant. One of his patients operated upon in 1888 had the right adnexia removed and the left tube resected for hydrosalpinx, became pregnant and aborted in April, 1889.

In order to secure pregnancy it is not necessary to preserve the ovaries and the uterine tubes in pairs, as the following case will show: Reported by Howard A. Kelly. M. B. came to him in February, 1895, invalided by a con-



stant dull pain in the lower abdomen, with severe exacerbations. On opening the abdomen March 27, 1895, he removed a left ovary converted into a large hematoma, and a little, withered right tube with a knobbed, closed end covered with lymph. The left tube was normal, and the right ovary was also normal except for numerous shreds of lymph attached to it and covering also the posterior surface of the retroflexed uterus. The uterus was held forward by picking up a plica of the vesical peritoneum near the symphysis and attaching it to the fundus on both sides. The left tube and the right ovary were left hanging down into the pelvis, with the fimbriated end of the tube four centimeters distant from the ovary. Pregnancy occurred in September of the same year, and the patient had her first child in June, 1896. In November, 1897, he had to remove the left tube for a ruptured extra-uterine pregnancy.

Uterus retroflexed; appendages firmly adherent; ovarian cysts opened; pregnancy within four months. A. P. Dudley relates a case of a woman twenty-five years old, operated upon by him in December, 1889. The uterus was retroverted, and with the appendages firmly fixed in the pelvic floor. The adhesions were broken up and numerous cysts in the ovaries punctured and evacuated, and the lining capsule scratched to cause it to fill with a blood clot. The tubes were probed and found patent. The uterus was held forward by an intraperitoneal shortening of the round ligaments. The patient left the hospital in three weeks feeling well, and in four months reported herself pregnant. Later she induced abortion by injecting hot water into the uterus.

Extensive inflammatory disease involving right and left ovary; left tube normal; ovary atrophied; pregnancy. In an other patient of Dr. Dudley's forty years old the uterus and appendages were firmly fixed in the pelvis by an inflammatory mass. The right appendages, hopelessly diseased and involved in adhesions, were removed, but the left tube was sound with an atrophic ovary. Sixteen months later, in her forty-second year, she gave birth to a healthy boy weighing seven pounds.

Left pyosalpinx and imbedded ovary removed; right adherent tube freed and cystic ovary punctured; adherent uterus elevated and suspended; pregnancy. This patient of B. MacMonagle is an interesting example of successful conservatism and an extraordinary success after suspension of the uterus. She was thirty-four years old, and had one child. The abdomen was opened for extensive pelvic peritonitis and retroflexion with adhesions. A left pyosalpinx with a densely adherent ovary was removed, and on the right side the tube was freed from adhesions binding it down to the pelvic floor, and several large cystic-follicles were punctured. The uterus, adherent by its posterior surface, was elevated and suspended by two sutures. Within a year she became pregnant and was confined at term, attended by a neighbor who acted as midwife. Three children were born: all lived, and they were two years old at time of report.

Normal involution went on, and the uterus remains in anteposition.

Retroflexed uterus and appendages imbedded in adhesions; left ovary and tube removed piecemeal; right ovary and tube badly torn; tube broken off five centimeters from uterus; pregnancy in six months. B. F. Baer reports a case of pregnancy under the most unusual circumstances. The patient, thirty-two years of age, who had a large retroflexed adherent uterus with hard masses on both sides, submitted to an operation, with the express proviso that one ovary or a part of one should at least be left, that she might not be deprived of the possibility of offspring. The abdomen was opened in February, 1891, and the retroflexed uterus and appendages were found so covered by organic false membranes as to be completely out of sight. After breaking through the false membranes with great effort, the uterus was dissected loose and brought forward, covered with shreds of broken adhesions. The left ovary and tube were so firmly bound down to the posterior surface of the broad ligament that they were taken away piecemeal, and a calcareous mass also removed from the bed of adhesions. The right side was similarly diseased and dissected loose in shreds, the tube being torn off five centimeters from the uterus. As Dr. Baer was about to remove the appendages of this side too, he received a positive injunction from the brother of the patient, who was a physician, and was present, not to proceed, as he preferred to assume any risk rather than deprive his sister absolutely of all hope of offspring. The abdomen was therefore closed, an excellent recovery followed, and in fifteen months a child was born.

Extensive pelvic inflammatory disease; right tube and ovary removed; pus sac in left tube opening into bowel; left tube amputated; pregnancy. One of the worst cases for the complications it presents is that of B. MacMonagle. The patient, twenty-four years old, had been married three years without pregnancy. She had a pelvic abscess discharging at intervals through the rectum, and following a dilation of the cervix at the hands of another specialist. When seen by Dr. MacMonagle in October, 1888, she was emaciated, sallow, had constipation, frequent urination, and night sweats. The abdomen was scarred and discolored by blisters and poultices; the temperature varied from 99° to 101°; a bad-smelling yellowish discharge issued from the uterus and vagina, and pus and blood appeared in the stool every few days. The uterus was fixed, and there was thickening and tenderness over both ovaries and uterine tubes. The abdomen was opened and the omentum found adherent to the uterus and the neighboring parts. There was a small cyst over the right tube and ovary, and extensive adhesions of the tube and ovary to the bowel and broad ligament, with the fimbriated end of the tube bound down to the ovary. The cyst, ovary and tube were removed close to the uterus. On the left side in attempting to enucleate the tube and ovary, a pus sac in the pelvis

opening into the bowel was broken into—and there was a sharp hemorrhage; the attempt was made to check this by putting a ligature (Staffordshire knot) deep down in the broad ligament, passing the loop on one side close to the horn of uterus and on the other side the ovary. When this was drawn tight it was found to include the ovary and adherent fimbriated extremity of the tube to such an extent that it was impossible to remove these structures and still leave enough tissue distally to prevent the ligature from slipping. Only the free portion of the tube was then cut out, and the incision closed with a glass tube drain inserted. Two years after she became pregnant and gave birth to a child.

Ovarian cysts of both ovaries; right ovary and tube extirpated; left cyst removed, leaving a piece of the ovary and the tube; pregnancy.

A woman thirty years old was operated upon in May, 1890, by A. Sipple for double ovarian tumors. On the right side no sound tissue was found, and the ovary, about the size of a child's head, was removed with the tube. On the left side the ovary was about as large as a goose egg, and at its base a strip of microscopically normal ovarian tissue was found. The tumor was therefore cut away, leaving a piece of ovarian tissue at the hilum four centimeters long and three or four millimeters in thickness, which was sutured and dropped. This patient became pregnant in August, 1891, and was normally delivered in due time.

Left ovarian cyst and adherent uterus; half of the right ovary removed; tube not removed; pregnancy. In another patient of Dr Dudley's, twenty-nine years old, an ovarian cyst firmly attached to the posterior uterine surface, was removed, leaving the uterus denuded. One-half of the left ovary was taken away, but the tube, though much enlarged, was allowed to remain, and the uterus fastened forward. Drainage was used through the vaginal cul-de-sac. Pregnancy occurred, and she miscarried at four months.

Hematoma of both ovaries; removal of left ovary and tube, resection of the right ovary; pregnancy. Operation of W. M. Polk, December, 1892. The left ovary, converted into a hematoma five centimeters in diameter, was removed with its tube. Two-thirds of the right ovary containing a hematoma was resected and the remainder brought together by suture. The right tube was not diseased. The patient recovered her health, and when seen June 5, 1893, was four and a half months pregnant.

A. Martin reported a case of pregnancy in a woman forty-two years old, operated upon in October, 1888, from whom the right adnexia had been removed and the left tube resected for hydrosalpinx. She miscarried in the third month.

Dr. Polk presents further a remarkable example of the possibility of re-juvenation in a case of double hematosalpinx. The patient was twenty-two years old, was operated upon in October, 1890. The right ovary, the seat of an extensive hematoma, was removed with the

right tube; on the left side the ovary was normal, but the tube, the seat of a hematosalpinx, was cut off just inside the dilated portion, about an inch from the uterus, and the stump attached close to the ovary. There were extensive adhesions on both sides. Two years after the operation the patient was delivered of a healthy male child.

Now I wish to report the following case: Mrs. H., German, age 25 years. Began to menstruate at the age of 15 years. No pain for two years, then severe pain all at once so great that she had to consult or employ a physician at each period, but nothing seemed to help her, but after marriage she became pregnant and after due time a boy was born. She menstruated once with great pain, became pregnant again, and on January 4, 1899, I was first called to see her in labor. She had a midwife with her, and it being a shoulder presentation she could not deliver. The child was dead. Woman exhausted and infected. Dr. Hatch and I delivered her; she had fever. I curetted, irrigated and packed her uterus January 7th; she soon recovered. Her period returned once; she became pregnant again. At the periods she suffered great pain. At the seventh month I was sent for and found her in labor, shoulder again, and arm down. This was January 7, 1900. Dr. Christie, Jr., gave chloroform, I turned and delivered. She made a good recovery, but pain at periods returned very severe, requiring morphine hypodermically. The pain always increased as the flow increased. March 7th made an exploratory vaginal section and released left tube from adhesions. Drs. Christie, Jr., and Zimmerman were present.

August 1st pain at periods still so severe I opened up abdomen, thinking best to remove both tubes and ovaries. After removing left tube and ovary for abscess of ovary, we decided to leave the appendages on right side. Drs. Christie, Jr., Gill, Hatch and Henry were present. Ether was given. Went home at end of three weeks; pain better for one period, then returned as bad as ever, became pregnant again in short time, the pains growing worse as the foetus enlarged, nothing gave relief; it confined her to her bed. December 10th I opened the abdomen again and found the fundus of the uterus bound down by adhesions of right tube to pelvic floor. I broke up the adhesions and the uterus returned to its proper position at once. The foetus could be distinctly felt through the uterine wall. Abdomen closed with through and through stitches of silk worm gut. Drs. Hatch, Rice and Wills were present. Stitches removed ninth day; wound healed. Did not have any more pain or trouble until the 8th of the following March, when she was taken with severe labor pains. I was called, found the membranes protruding and in a few minutes a female child of about six months was born. She had had a diarrhoea during the day.

April, May, June and July periods so painful had to have hypodermics of morphine and atropine. At these periods the pain was as severe as any case of labor I have ever at-



tended, and they confined her to her bed for one week. Despairing of any relief without bringing on the menopause on July 22, 1902, I opened the abdomen again and did a hysterectomy and removed the right ovary and tube. Amputated the uterus above the vaginal junction. Dr. Hatch assisted me and Dr. Rice gave chloroform followed by ether. She made an uneventful recovery. Changed dressings first time tenth day; removed stitches at this time; wound healed. Left hospital nineteenth day after operation. You can imagine the severity of her sufferings during her periods as the nurse was preparing her for the operation asked her if she did not dread the operation, and she said, oh no, I suffer more in one day at my periods than I did altogether following the operations.

I saw her while she was visiting at the hospital several weeks later. She was well and strong, said she was feeling fine; no pain.

Of the 139 cases reported here, there were 23 cases of pregnancy in all; 13 children born at term from 10 women; triplets once; 6 pregnant at time of report.

Five abortions or miscarriages.

One case of extra-uterine pregnancy requiring removal of tube, but this woman had given birth to one child at term since the removal of right tube and the left ovary by Dr. Kelly.

Two deaths followed the operations.

C. D. Center read an essay on **The Malignant Tumors of the Breast.**

Divided in two general classes, differing in structure, in appearance, in objective and subjective symptoms, in the history, in the age of the patient, in their manner of developing and progressing, while they may not differ in malignancy, in the outcome if left unremedied, nor markedly in the manner of correctly caring for and relieving them.

The malignant tumors of the breast have, from the beginning of medicine and surgery, been looked upon both by the profession and laity with more or less of abhorrence and fear. Even yet to the laity the diagnosis of cancer of the breast is the terrifying announcement that the afflicted one is doomed to a long, slow torturing process, ended only when the grave envelopes its victim, and this haven not gained until the unfortunate sufferer has become an object of loathing to herself, and when the sympathy and pity of her immediate friends must of necessity be mingled with the natural repulsion the healthy organism has for an ill-concealed, or still worse, an impossible to conceal, disfiguring and oftentimes disgusting disease. There is too, something naturally abhorrent to the practitioner of medicine in the case he knows is incurable, as so many malignant breast cases are. Add to this abhorrence for the irremediable disfiguring ulcer, a fetid odor, an arm and hand swollen to thrice its natural proportions, the account of days of pain and nights of physical and mental anguish and the beseechings of the afflicted one's friends, and a malignant tumor of the breast becomes justly an object of fear and abhorrence by both the professional man and his lay brother. As to fear it may be said

without danger of contradiction that the patient and her friends always fear malignancy. The doctor must fear it if through his own dilatoriness, or that of a brother practitioner the case has been allowed to progress unimpeded, or still worse, the disastrous and dreaded outcome even assisted by halfway, or ill-advised measures.

There has been, and is now, too much of this waiting for development, dallying with time in order that the case may be diagnosed visually when a closer acquaintance with the morphology of these tumors could make an accurate diagnosis early in the case. The rule should be drawn as stringently for cases of breast tumor as for broken bones or dislocated joints. The latter classes furnish a large percentage of the openly criticized cases, the cases talked over in court, when as a matter of fact the attending physician is often less deserving of a malpractice suit than many have been and are with their cases of breast malignancy.

In this paper, brief as it must be, I do not wish to discuss the malignant tumors of the breast from either a microscopical nor histological standpoint except in a very general way. The main object being to speak of those features that help the practitioner to make an early and accurate diagnosis.

For practical convenience let us divide these tumors into two great classes, the carcinomatous and the sarcomatous, allowing the modified and combined forms of each variety to have weight only inasmuch as they are also malignant, if cell forms of either of the great varieties enter into their composition. As an illustration, the adenoma type of tissue structure may overshadow the sarcoma type, but it is not less a malignant tumor so long as the sarcoma cell is there.

**Diagnostic Indications.** According to one author 83 per cent of all cases of breast tumor are carcinomatous, either from the beginning or becoming so later in the development, allowing as he does for an induced malignancy in the area of irritation, or of neoplastic encroachment. This percentage, *per se*, furnishes a bias for the diagnosis. But it is not one fact, one table of statistics, one objective reason which makes up the accurate diagnosis, but all the facts, all the lights and shadows, the harmonious blending of clinical colors that makes the complete and uncontroverted clinical picture. To quote from another author, it is probable that the larger portion of mammary tumors that come to the general practitioner are either markedly scirrhus or bordering on this type. These quoted opinions coincide, and corroborate, since the carcinomata are bodies or net works of connective tissue, the alveolae of which are filled with the carcinoma cells, or cell masses, with excess of the connective tissue. This connective tissue, unless it be of extremely rapid development, contains an excess of fibrosity, and if accompanying, or subsequent, fatty degeneration did not set in this excess of fibrous material would always be found. Often it may be determined in one part of the tumor only; in short time cases in the



older part of the growth, and in long time cases in the more recent involvement, for the remainder of the tumor being of sufficient age has undergone the secondary change and become softened. There is a direct ratio too between the degree of fibrosity and the malignancy, and between the rapidity of the softening, or degenerative change, and the malignancy, some carcinoma being so exceedingly malignant that the fibrous stage is practically evanescent. This fibrosity of the carcinoma gives another very significant diagnostic point, i. e., dimpling to the sight, cutaneous adhesion to the touch. The fibrous fasciculi run in all directions. Internally they lay hold upon the muscle fascia, externally the skin, the result being a rope of connective tissue, prone to contract, fast at each end. The skin offers less resistance than the deeply imbedded fascia and yields, is pulled inward at the point of attachment forming a dimple. From this stage of carcinoma development the skin is fixed above the tumor and is involved in the malignancy. It may be said here that retraction of the nipple will not occur in carcinoma unless this connective tissue rope has followed up or along the milk ducts to the nipple apex. Billroth gives a diagnostic feature found immediately before skin dimpling sets in, and calls attention to the "nodulated feel," claiming that at each one these short points fibrous connection has been made which will later contract to cause the characteristic dimpling. Senn sums up this aspect of the case by saying "a nodulated fixed tumor of the breast is in all probability a carcinoma."

**History.** In eliciting family and personal history from a patient with breast tumor, too much dependence must not be placed on her statement relative to the time of existence of the growth. The personal history must have weight only inasmuch as it confirms the conditions according with the clinical findings. Many patients will have had a non-painful scirrhus nodule in the breast for months before it is discovered. But few patients have noticed closely enough to say definitely whether the skin was or was not, adherent when they noticed the tumor. **Heredity** in breast malignancy is not a factor in making up a diagnosis, but like the statistics first quoted will of necessity cause a greater or less amount of bias in the diagnostician's mind. One well known author maintains that the only effect heredity has in malignant growths is the factor arising within the patient's mind, i. e., the mental depression, or mental perversion in this direction, this expectancy of malignancy causing a lessening of tissue resistance. Such a condition would be found with equal frequency in either carcinoma or sarcoma. A belief which prevails today, apparently on good grounds, is that based on the infectious nature of cancer. The fact that many men or women working in certain fields or factories, or living in definite houses, or in a given area, give a very high percentage of cancer cases would seem to show that certain atmospheric conditions, or certain non-hygienic or non-sanitary conditions will develop cancer irre-

spective of heredity, and would seem to tend to prove at once the probable infectious nature of the disease, and the slight bearing heredity has in the matter. A theory—containing a considerable degree of fact—is that certain diatheses, namely, those which may be distinguished as the acid, furnish the cases of carcinoma, while another diathesis called for convenience the alkaline is immune, and it is no doubt a fact that lithaemic persons or those of lithaemic ancestry do furnish our carcinoma cases. I do not believe the same can be said to hold true with sarcoma cases.

Another differential point, not infallible but reasonably good, is **age**. Roughly we may say sarcoma before thirty-five, carcinoma after thirty-five. The modifications of this rule are these: If other indications point to carcinoma before the age of thirty-five look for a soft, rapidly growing, and excessively malignant tumor. One that has sprung up in weeks instead of months. One that has made vast encroachments upon the mammary gland, has extensively invaded the lymphatics, but time has been insufficient to produce cancerous cachexia or much loss of weight. It is an atypical carcinoma; soft like the sarcoma, smooth like the sarcoma, and for a considerable time at least, non-painful like the short time sarcoma. It lacks the dimpling and the nipple retraction. It will also lack the venous hyperaemia and the duct hypertrophy of the sarcoma.

To repeat what has become almost axiomatic, a sudden change or increase in the growth of a mammary tumor is practically always a sign of malignancy, and I think other observers will bear me out in saying of carcinoma. Excessive rapidity in growth is not only a sign of malignancy, but in like ratio to its rapidity of excessive malignancy. Extreme rapidity of development from the initial appearance cannot, however, be said to be more indicative of carcinoma than of sarcoma.

**Pain** is not a reliable indication for either carcinoma or sarcoma. Neither is painful until a nerve filament is compressed in a nodule of the carcinoma, or between venous sinuses or hypertrophied ducts in the sarcoma, or has become infiltrated and distended by the atypical cells from either class, or has fallen into a neuritis, or neuralgia, from the local toxæmia. Senn lays down this rule: Simple adenoma is more painful than either carcinoma or sarcoma.

**Development.** The manner of progression of these two tumors is of the utmost importance in a differential diagnosis. The carcinoma, as said, is a cellular structure in which interstitial substance predominates. Its cells have amoeboid action. Traveling as it does by infiltration it evades all soft tissues that impede its way. Its progress to other than adjacent parts, is, unlike the sarcoma, by the lymph channels. The sarcoma, being largely cell growth, with less of the interstitial substance, has blood vessels coming in intimate contact with its cellular substance. The vessel walls are filled with cells. Some are pushed through, fall into the blood current, and are carried to remote parts of the body. The car-

cinoma has its blood vessels in the stroma. The cells and cell masses, or nests, are more clannish than those of the sarcoma. They nest together; they show no predilection for the vessel walls. During their emigratory, or infiltration process, they are taken up by the body scavengers, the lymphatics. At the filters, the lymphatic glands, they are removed from their nutrient fluid by the gland. This gland, for a brief period, undoubtedly checks the carcinomatous progress, but the overwork, and the clogging up by the constantly arriving carcinoma cells ultimately causes glandular death, and upon the gland ruin we have implanted a daughter carcinoma. According to Green the rapid development of a carcinoma when once it diffuses by the lymphatic route is accounted for by the carcinoma cells being bathed all the time in so rich a nutrient medium. Senn goes farther and says these cells not only take advantage of this nutrient fluid but actually work their way onward by amoeboid movement endeavoring to outstrip in its current the lymph stream. The two great methods of progression cause two distinct results. The sarcoma, vascular hypertrophy; the carcinoma glandular hypertrophy. The sarcoma involving the vessel walls with cells causes a lack of the normal tonicity of the wall coats; the vessels dilate, become enlarged, even become sinuses, and the result is a tumor marked by large, numerous, and frequently tortuous blood channels. Naturally the greater and more rapid this development is the greater the malignancy is. This vascular condition of a sarcoma together with the hypertrophy of the milk ducts of the gland, gives often a true fluctuation or palpation.

The late difference in the gross appearance of the two classes is usually quite marked. Then it is that the carcinoma becomes a cancer, a crab, an eating neoplasm pushing out a finger in this direction and another in that. The sarcoma is more liable to be a fungous sore, characterized by considerable extravasation of blood, rapid necrosis of the fungous granulations and accompanied by a constant discharge of fetid, sanious fluid. One other point in the differential diagnosis, and one seldom brought out; the reticent mobility of the arm on the affected side quite early in the development of a carcinoma due to the tenderness of the hyperaemic and overworked axillary and clavicular lymphatics.

The discussion was participated in by Drs. Christie, Jr., W. W. Williams, E. B. Montgomery, Robbins, Knapheids and J. A. Koch, and closed by Dr. Center.

E. B. Montgomery during the discussion spoke of a case of malignant tumor of the breast that he operated on during the past week. He did the classical "Halsted" operation and a slide mounted by John A. Koch showed a beautiful specimen of carcinoma durum.

Fifteen members were present: Drs. Ashton, Center, Christie, Jr., Christie, Sr., Knapheide, Knox, E. B. Montgomery, H. J. Nichols, Robbins, Rosenthal, Sigsbee, Vasen, Wellenreiter, W. W. Williams, and John A. Koch.

John A. Koch, Official Reporter.

The Bureau County Medical Society held its eighteenth semi-annual meeting at the city hall in Princeton, Illinois, Thursday, November 13, 1902, M. H. Blackburn, president, in the chair. The roll-call showed twenty-two active members present. The following made application for membership, and were duly elected: A. L. Skoog, Matthew Ohaver, C. C. Barrett, M. J. Coveny and V. A. Peterson. Visitors present were E. P. Cook, Mendota; E. H. Ochsner and A. H. Andrews, Chicago.

The ordinary business of the society was transacted, and the following officers elected: President, W. E. Howard, Ohio; first vice president, J. H. Franklin, Spring Valley; second vice president, C. H. Kemp, Tiskilwa; secretary and treasurer, O. J. Flint, Princeton.

A bill, known as the Bureau County Fee Bill, was presented and adopted, and a committee appointed to make any amendments that were deemed advisable, the same to be presented at the next meeting of the society.

The proposed bill for the establishment of a State Board of Medical Examiners, and the regulation of the practice of medicine, came up for consideration before the society, and the proposed bill was fully endorsed. The society voted to give ten dollars out of the treasury to the Legislative Committee to aid them in their efforts.

The following papers were read:

**Eczema**, by Jessie Pierce Garwood, Princeton.

**Cystoscopy of the Female Bladder**, by Edgar P. Cook, Mendota.

**Early Operation in Appendicitis**, by MacClarey Weeks, Spring Valley, paper read by J. H. Franklin, Spring Valley.

**Observations from the Clinic of Prof. Lorenz**, by William Keller, Princeton.

**Septic Infections**, by E. H. Ochsner, Chicago.

**Adenoids and Their Relation to the General Health**, by A. H. Andrews, Chicago.

The papers were especially interesting, and brought out a very general discussion.

The meeting then adjourned, to meet again the second Thursday in May, 1903.

The president has since appointed the following members of the various committees:

**Program:** O. J. Flint, G. M. Russell, J. S. Remsburg.

**Arrangement:** C. A. Palmer, C. C. Scott, Jessie P. Garwood.

**Publication:** Hattie M. Owens, Richard McCarthy, S. E. Williams.

**Censure:** A. E. Owens, S. W. Hopkins, S. C. Thomson.

O. J. Flint, Official Reporter

The Chicago Gynecological Society met November 21, 1902, President C. S. Bacon in the chair.

Carl Wagner (by invitation) presented the following specimens with remarks on the clinical history of the patients from whom they were removed:

1. Uterus with large fibroid of cervix and lower segment of fundus, blocking the pelvis; extirpation during labor with fetus in situ.

2. Large sarcoma of ovary as a complica-



tion of pregnancy.

3. Uterus didelphys seu Duplex separatus cum vagina septa.

4. Uterus bicornis with large fibroma in each horn and also multiple fibroma around the small fundus.

5. Ovarian dermoid cyst.

6. Ovarian stone.

7. Fibroma of posterior lip of cervix extending into the posterior part of the fundus.

Remarks were made by R. W. Holmes and J. C. Hoag.

Bertha VanHoozen (by invitation) reported a case of **Sarcoma of the Uterus arising in a fibroid**. Discussion by M. Herzog and J. C. Hoag.

Frank B. Earle presented the report of two cases of **extrauterine pregnancy at term**, and presented the specimen from one of them. The discussion was participated in by M. Herzog, A. H. Tagert (by invitation), J. C. Hoag, J. T. Pickrell, J. Clarence Webster, Carl Wagner, C. S. Bacon and R. W. Holmes.

Palmer Findley read a paper entitled **Hydatidiform mole, with a report of two cases, and clinical deductions from 210 reported cases, with exhibition of specimens**. In the discussion J. B. DeLee took up the consideration of the clinical aspect, and J. Clarence Webster discussed the pathology of the condition. Carl Wagner briefly presented a case of hydatidiform mole he had some years ago.

R. W. Holmes, Official Reporter.

The **Chicago Electro-Medical Society** held its annual meeting and sixteenth regular meeting in room 912, Masonic Temple, Wednesday, November 26, 1902, the first vice president, Dr. Pettyjohn in the chair. Five new members and two associates were elected. The total membership is now 67. The society has been in existence since June 25, 1901, and has done very creditable work.

Two months ago a faction made an attempt to disrupt the organization. The matter was taken into the courts and decided in favor of the society. Details of the attempt may be found in the official organ of the society. The *American X-Ray Journal*, for October and November.

The following officers and committees were elected for the ensuing year:

President—Elmore S. Pettyjohn.

First Vice President—W. K. Harrison.

Second Vice President—John E. Gilman.

Third Vice President—E. G. Trowbridge.

Secretary—T. Proctor Hall.

Treasurer—Wm. E. Holland.

Executive Committee—H. Preston Pratt, R. H. Bartlett, John P. Webster.

Membership Committee—J. L. Hammond, P. S. Replogle, Hamilton B. Forline.

Publication Committee—H. Preston Pratt, A. W. Smith, J. E. Harper.

Judiciary Committee—L. D. Rogers, Frank Duncan, W. A. Pratt.

On motion the following resolution was adopted:

Whereas, The report of the Committee on Scientific Research, which was unanimously

adopted by this society March 25, 1902, showed that H. Preston Pratt, a member of this society, was the first to make use of the X-rays for therapeutic purposes; and

Whereas, Claims of priority in this work have been made and are still being made in behalf of other persons; therefore

The Committee on Scientific Research is requested to extend and complete its historical investigations regarding the therapeutic use of the X-rays during the years 1896 and 1897.

The president-elect read an interesting paper on **Electro-Therapeutical Practice**, giving the general results of his experience in this work during the last twenty years. After discussion of the paper the meeting adjourned.

T. P. Hall, Official Reporter.

The **Chicago Medical and Ophthalmological Societies** held a joint meeting Wednesday, December 17, 1902, in the Schiller building, with William H. Wilder in the chair.

Alfred C. Cotton read a paper on **Some Eye Disorders in Children Influenced by Malnutrition, Diathesis and Dyscrasia**.

Of the eye disorders in infancy and childhood, etiologically considered, he thinks the two extremes are perhaps best represented by ophthalmia neonatorum and phlyctenular conjunctivitis. In the former, we have an acute fulminant process due to specific infectious germs which produce with marked regularity typical inflammation of the conjunctiva, regardless of the conditions of general nutrition, diathesis or dyscrasia. In the latter, we have a destructive lesion of the conjunctiva or cornea, with no etiological microorganisms invariably attacking only the eyes of subjects of malnutrition, or the so-called strumous type.

The importance of ophthalmia of the newborn is so generally understood as to require no more than passing notice. Whether the family physician adopts the Crede method as a regular routine practice, or is content with the cleansing of the eyes of the new-born with boric acid, saline solution or sterile water, he should not forget that the responsibility for protection from the effects of acute purulent ophthalmia rests solely upon him. Two general principles must be observed: First, to cleanse by irrigation the conjunctival sac from purulent accumulations as frequently as the individual case may require; second, the maintenance of hygiene, including rest and nutrition. The intractability of acute local inflammation is increased by depressed constitutional conditions and innutrition is sufficient to make rest and nourishment of supreme importance. Of the many local remedies employed in purulent ophthalmia, each has proved efficacious in the hands of different practitioners. Protargol, in ten to twenty per cent solution, has proved highly satisfactory.

Phlyctenular affections belong distinctively to the period of late infancy and early childhood. It is one of the local manifestations of the strumous diathesis.

Closely allied to phlyctenular affections is conjunctivitis following the eruptive fevers of childhood. In these cases routine application



of astringents should be discouraged. Two other forms of conjunctivitis require prompt constitutional treatment, namely, the croupous and the diphtheritic types. The first is rarely seen except as an accompaniment of depraved constitutional conditions. The treatment should be locally palliative, constitutionally nutritive and hygienic.

Of the other dyscrasias upon which serious eye lesions depend, syphilis is undoubtedly the most common. From the standpoint of the general practitioner, the ophthalmic lesion most in evidence in children with inherited syphilis is interstitial keratitis. Regardless of the value of mercurials in controlling syphilitic manifestations in later life, the essayist says there is abundant clinical evidence in favor of its exhibition, preferably by inunction, in children. This should be accompanied by the best known tonic and supportive measures.

#### **The Most Prevalent Eye Diseases Among Children.**

F. C. Hotz read a paper on this subject. He said that certain diseases of the eye are more frequent in children than in adults. In these, malnutrition plays a conspicuous role. The principal ocular affections coming under this head are: (1) Ulcerative blepharitis. (2) Phlyctenular keratitis and conjunctivitis. (3) Interstitial keratitis, due in from 50 to 80 per cent of cases to inherited syphilis, and affecting persons between the ages of five and twenty years. The disease is not the outcome of actual specific lesions in the eye, but stands in close relation to the debilitated state of the system existing in victims of inherited syphilis.

Charles H. Beard followed with a paper on **Arterio-sclerosis of Retina and Choroid.**

Among other things, he stated that the first of the frequently noticed results of blood vessel disease in the retina was unwonted meandering in their courses. This applies not only to the lateral planes, but to the vertical ones as well. They rise and they dip. These flexions toward and away from the spectator seem to be mainly on the part of the larger twigs. This phenomenon is strikingly shown in the more advanced cases at the points where veins and arteries cross. The artery, being more rigid, seems not so much to leap over the vein as the latter to depress itself.

Another early and conspicuous sign of arterio-sclerosis is white lines, which accompany the large trunks from the lamina cribrosa for varying distances along their courses. This is thought to be pathognomonic of senile arterio-sclerosis and is to be differentiated from similar appearances which are the result of thickening of the adventitia, and obliteration of the perivascular lymph spaces, which often follow neuro-retinitis. In the latter the caliber of the vessels is not necessarily narrowed, as it is in arterio-sclerosis. The condition may also be simulated in another way by the rich frame-work of connective tissue which often normally surrounds the vessels in this vicinity and radiates from the disc. Added to the deception may also be physiological tortuosity of the vessels. As the process waxes and spreads come other changes. There occur infiltrations

of the retina which are not necessarily visible, and these in turn become in-growths which show themselves as narrowing of the blood column. These growths undergo various forms of degeneration, at one time revealing themselves as small yellowish patches on the vessel, or as tiny white scales. Haab associates the last with syphilis.

Hemorrhages, large and small, are apt to occur in all stages, and one can usually distinguish between the old, the more recent and the fresh ones by their color and general appearance. The larger hemorrhages are prone to originate at the vessel crossings or where large branches are given off. Later the clot may become organized and assume the look of white, fluffy cotton, connective tissue new growths, stained in spots with dull or bright blood.

At a given period in arterio-sclerosis of the retina, the fundus may show all the features that have been associated with an albuminuric neuro-retinitis, and the outcome may be optic atrophy.

A not infrequent ophthalmoscopic picture in these cases of blood vessel disease of the retina is that which has been named embolism of the central retinal artery.

With regard to the eye itself in cases of arterio-sclerosis, the utmost discretion should be exercised in the use of mydriatics, and operations upon that organ should be undertaken only after the most careful general preparation. By these means we may be spared participation in grave disasters, such as intra-ocular hemorrhages, which produce glaucoma and expulsion of the contents of the globe after cataract extraction.

#### **Organic Diseases of the Nervous System Causing Focal Ocular Symptoms.**

Sanger Brown read a paper on this subject, in which he pointed out how a lesion of the chiasm may interrupt the visual path from the nasal half of each retina, thus producing temporal hemianopsia. This symptom is met with not infrequently in acromegaly, as a result of the associated hypertrophy of the pituitary body; also in dilatation of the third ventricle from whatever causes produced. The change in the visual field that results from a lateral extension of a destructive lesion commencing mesially is obvious, and so, too, would be a lesion of the non-decussating fibers which must produce nasal hemianopsia. A destructive lesion of the visual path anywhere between the chiasm and the occipital cortex must cause homonymous hemianopsia; but if it be in or anterior to the external geniculate body, pulvinar and anterior corpus quadrigeminum, the fibers constituting the path for the pupillary light reflex corresponding to the insensitive retinal part would likewise be interrupted; and hence, when these parts of the retina alone are exposed to light, there will be no pupillary response. On the other hand, if the lesion be between the intermediate centers named and the occipital cortex, the pupillary fibers escape, and there will be no disturbance of the light reflex.

A hemorrhage into the cuneus of one side might cause sudden and complete blindness by destruction of the visual elements on that side,

and pressure on those of the other. Ultimately, as the pressure was relieved by absorption of the clot, there might remain only homonymous hemianopsia. Conversely, the visual symptoms from a growing neoplasm in the same situation might extend from homonymous hemianopsia to the gradual production of complete blindness, as the contra-lateral lobe became compressed. It has been shown conclusively by Schaefer in monkeys that the cortex of the occipital lobe represents homonymous parts of the respective retinæ in zones. That is to say, if the superior half of the left occipital lobe in the monkey's brain be excised, the left upper quadrant of each retina will be rendered insensitive to light, with consequent production of homonymous temporal hemianopsia in the lower left quadrant. This fact, he thinks, may be safely transferred to the human subject. It affords a rational explanation for sector or quadrant hemianopsia.

The association of hemia-anesthesia and hemiplegia in which, perhaps, the leg suffers more than the arm and face, with homonymous hemianopsia, presupposes a lesion in the posterior part of the internal capsule, interrupting the efferent motor or pyramidal tract, together with the afferent sensory path for the opposite side of the body, as well as the optic radiations. This combination of symptoms occurs most frequently as a result of cerebral hemorrhage; whereas the association of hemianopsia with hemiplegia, without sensory symptoms, is more often due to a neoplasm injuring the optic tract and contiguous parts of the crus, although the cause may be transposed in the two cases.

He stated that the exact location of the pupil-dilating center is not known. It is quite certain, however, that it is in the Sylvian gray matter, near the other oculo-motor nuclei, and the axones emanating from it pass through the pons, medulla and cord, to issue by the anterior root of the first or second dorsal nerve, whence they pass by the cervical sympathetic to the ophthalmic division of the fifth, to the ciliary ganglion and by the long ciliary nerves to the long radiating fibers of the iris.

The author then spoke of lesions of the third nerve in any part of its course, or of its nucleus, saying that they caused paralysis of all the external ocular muscles, except the external rectus and superior oblique.

Henry Gradle discussed **Eye Affections as Early or Characteristic Evidence of Nervous Diseases**. Paralysis of the eye muscles, if not of peripheral origin, may indicate tabes or basal syphilis. Progressive multiple palsies show involvement of the nuclei of the motor nerves of the eye. Acquired nystagmus may be part of disseminate sclerosis, Friedreich's hereditary ataxia, or cerebellar disease. Pupillary inequalities often precede general paresis and other degenerative forms of insanity. Paralysis of the iris sphincter may be the only sign of cerebral syphilis. The importance of the narrow rigid pupil as an early sign of tabes or general paresis is well known. Optic atrophy not rarely precedes all other manifestations of tabes. Choked disc aids materially in the diagnosis of brain tumors, while optic neuritis

without edema may point to inflammatory cranial affections. The diagnosis of hysterical blindness depends mainly on the presence of normal pupillary reaction. The paper concluded with the inferences to be drawn from a study of hemianopsia.

The Chicago Surgical Society's regular meeting was held December 1, 1902, with President John B. Murphy in the chair.

J. H. Mustard and Frederick Tice (by invitation) reported **two cases of Splenectomy for Traumatic Rupture of the Spleen**.

Daniel N. Eisendrath did a splenectomy last winter at the County Hospital. In looking up the subject, he was surprised to find that prior to 1890 only three laparotomies had been done for traumatic rupture of the spleen, with a mortality of one hundred per cent. From 1890 to 1900, however, there were 34 cases operated on, the percentage of recoveries having increased from zero to 41 per cent. From 1900 to 1902 he was able to collect 50 cases, of which 28 recovered.

Arthur Dean Bevan suggested the use of the S-shaped incision in cases of splenectomy, instead of an incision parallel to the costal arch. This S-shaped incision he employs in gall bladder work, particularly in common duct work, and it answers very admirably. It has the advantage that if the surgeon finds he has some other lesion to deal with, the incision can be extended and the advantages of a mid-laparotomy obtained, and if it is the spleen, one could gain easy access for its removal.

D. W. Graham questioned the accuracy of the statistics of Dr. Eisendrath. While he could not recall the statistics, which he looked up more than twelve years ago, regarding splenectomy, he remembered that the only cases that had recovered from splenectomy were those from whom the spleen had been removed for traumatism. The general conclusion arrived at from those statistics was that the removal of the spleen for traumatism was a tolerably successful operation.

E. Wyllys Andrews suggested conservative surgery of the spleen, the same as conservative work is now being done on the intestine and kidney. An effort should be made to ligate the individual vessels that are bleeding in cases of traumatic rupture, and preserve the spleen.

M. L. Harris mentioned the value of making a blood count in all cases in which there is a probability of rupture of any internal organ as indicating the existence of intraperitoneal hemorrhage, instead of waiting several hours or until shock has become so extreme as not to be mistaken. Another point was the value of a blood count after splenectomy. The most notable change is the great increase in the relative proportion of the large mononuclears. In all cases, after splenectomy, done experimentally upon animals and on human subjects, it has been found that there is a large increase in the eosinophiles up to 10, 12, 14 and even 16 per cent. He mentioned one case of his own where the blood count had been watched carefully for over three years in a case of splenectomy for splenic anemia.



Bayard Holmes said a midwife in the neighborhood of Naples removed a spleen late in the seventeenth century or early in the eighteenth century successfully. The spleen was protruding through a wound in the side, which had occurred at some time; that great pressure was made upon the abdomen, and the spleen appeared. Being a midwife, and accustomed to tying things, she tied a string around the pedicle, cut off the protruding organ, and the patient recovered. If one went back to ancient surgery, he would find a number of cases of splenectomy performed under such conditions as that. Splenectomy, however, is an extremely modern procedure.

#### Carcinoma of the Larynx.

Arthur Dean Bevan exhibited a man upon whom he had operated for carcinoma of the larynx. The operation was done by the method suggested by Keen, of using no tube during or after the operation, by removing completely the larynx, bringing the trachea into the wound and stretching it in that position. The case was one of Dr. Dickerman's. He presented this case to the society before, with two other cases of carcinoma of the larynx, one that had been operated upon by the late Dr. Fenger, and one in which a tracheotomy had been done. An artificial larynx was not used in the case of this patient. The patient can make himself heard and understood at a distance of eight or ten feet, by a method of education. The patient uttered several words clearly and plainly. Dr. Dickerman finds that the man can pronounce all letters of the alphabet with the exception of two. An artificial larynx will not be used in this case, but simply a scheme of education, and the speaker thought there is no question about the desirability of this method over that of the use of a tube.

Jacob Frank said he presented to the Chicago Medical Society three years ago a man upon whom he performed laryngectomy, removing the hyoid bone and the epiglottis. This man could talk in a loud tone of voice, so as to be heard in a large room.

Professor R. Van Baracz, of Lemberg, Austria, read a paper entitled

#### Report of Sixty Cases of Actinomycosis, with Demonstration of Specimens.

The author selected this subject for two reasons: First, because the disease is rarer in this country than abroad; second, because he had made a special study of it, having had occasion during the last fourteen years to observe it in sixty cases. The reason for its frequency in Galicia is owing to the extensive farming done in that country.

As to the seat of the disease, he has had fifty-two cases of actinomycosis of the jaw and neck; three of the tongue; three of the thorax and lungs; and two of the abdomen. As to the abdominal form of the disease, he has had occasion to observe three more cases in the practice of colleagues, so that he has seen altogether five abdominal cases.

Actinomycosis, he said, is produced solely by a special form of fungus, the streptothrix actinomyctica. This fungus usually enters the body through the mucous membrane of the

mouth, of the air passages, or of the digestive tract. Very rarely does it enter through the skin. The transmitters of the disease are exclusively minute vegetable bodies, as the awns of barley and grass particles. The proof of this is the frequent finding of these bodies in actinomycotic abscesses. The teeth are never the portal of entrance. The cases cited by Murphy, Partsch and others, in which a communication between abscesses of the parts and the alveolus was found, or in which a fungus was found in a decayed tooth, are not sufficient proof, in his opinion, that the disease gained entrance through the decayed tooth. Evidence of the incorrectness of this route of infection is the lack of decayed teeth in actinomycotic cattle, and sometimes in human subjects; the impossibility of finding the fungus in decayed teeth, and the frequent finding of the fungus in the soft parts of the checks. He has himself detected such vegetable bodies in thirteen cases of cheek and tongue actinomycosis, but never in decayed teeth. In these he only found the *leptothrix buccalis*.

He showed a specimen of actinomycosis of the tongue, in which the center of the ray fungus colony was the awn of oats.

Decayed teeth play an important role in the etiology of the disease, as the softened and swollen gums allow of easy entrance of the fungus with a foreign body. The fungus rarely develops in the mucous membrane of the mouth itself.

Regarding the treatment, in the first forty cases the treatment was operative, consisting of curettement and extraction of teeth. As the disease generally produces a hard wall around the softened area, which hinders the extension of the process, he attempted in several cases to produce such a wall, which consists of connective tissue, by hypodermic injection of irritants, like tincture of iodine, and twenty per cent solution of nitrate of silver. In this manner he was able to cure his last nine cases without any operative interference. Nitrate of silver in sticks, or in twenty per cent solution, not only produces such a boundary of connective tissue, but kills the fungus.

Tongue actinomycosis occurs in the form of circumscribed or diffuse abscesses. In three cases of actinomycosis of the tongue, he found vegetable bodies in softened tissues. These were cured by opening and curettement.

In actinomycosis of the thorax and lungs, the prognosis is unfavorable. Three of his cases died. The fungus enters here by the air passages or the esophagus. In one case, at the autopsy, he found a fistula between the esophagus and the posterior mediastinum. These cases are not suitable for surgical treatment. He said the reported cures of lung actinomycosis must be considered *cum grano salis*, because of the short time for observation after the operation.

He believes that intravenous injections of collargol in actinomycosis of the lung and thorax will be of great service. He has attempted intravenous injections of the various soluble preparations of silver in a number of dogs and rabbits. For this purpose he used one to two



per cent solution of argonin, argentamin, largin, ichthargan and soluble colloid silver (collargol), in increasing doses, and the last proved the best, in comparatively large doses, according to the body weight of the animals. He observed no unpleasant symptoms.

As far as the fungus itself is concerned, he comes to the conclusion through personal observation that there is only one form of the fungus which produces actinomycosis. Some authors require cultures for a positive diagnosis of the disease, but he believes this to be unnecessary. The fungus can be easily discovered microscopically, and it is often possible to diagnose the disease microscopically with some degree of certainty.

He described this fungus at length.

Animal inoculation is not successful in actinomycosis.

Wm. T. Belfield said that soon after the discovery of the fungus of actinomycosis, he was called upon by the Health Commissioner of Chicago to investigate the nature of certain diseases of cattle at the stock yards, and found actinomycosis, which he thought was the first recognition of the disease in this country. Soon after this a case was recognized by John B. Murphy in the human subject, this being the first case occurring in the human being in this country, and which was brought to a successful issue. He said J. L. Sawyers, of Centerville, Iowa, had reported some eight or ten cases of actinomycosis, which had come under his observation, and who drew attention to the value of the subcutaneous injection of weak solutions of iodide of potassium. Dr. Sawyers had cured one case of actinomycosis of the lung by means of these injections, using something like one grain to the ounce. It was a method of treatment he had not seen recommended by others.

A. J. Ochsner had been interested in this disease since 1886, when he saw his first case of actinomycosis of the upper jaw, and of the lung. He had obtained excellent results by giving patients as much as ninety grains of iodide of potash, three times a day, in milk, with a pint of hot water. He has the patient take it for three days, then lets him go without it for four days, again repeats it a number of times, and then lets the patient go three or four weeks, and repeats it again. In this way one case has remained well for ten years.

In cases of intestinal actinomycosis, he believes if one depends upon iodide of potash it is better than if a radical operation is made. He had in mind a patient who suffered from actinomycosis which involved the entire appendix. The child had had an acute attack of appendicitis, apparently, and actinomycosis for a long time. On opening the abdomen he came upon a mass of actinomycosis tissue, simply washed it out with tincture of iodine, tamponed with iodoform gauze, and gave the child the regular treatment of iodide of potash, and the child has been well for four years. Cases in which a major operation is made are liable to die of starvation.

Arthur Dean Bevan asked whether there was any possibility of the X-ray being of ser-

vice in these cases. He said a combination of iodide of potash and X-ray treatment had resulted in cleaning up cases of blastomycetic dermatitis more rapidly than any other method.

A. J. Ochsner replied that he had used the X-ray in one case of actinomycosis of the upper jaw for a short time, and the patient was now well.

M. L. Harris mentioned a case of actinomycosis hominis involving the abdominal wall. An abscess formed slowly; it was opened; cultures were made, and the staphylococcus albus found. There was a small amount of pus, with a large amount of hard exudate, and in the pus were noticed little granules, which, under the microscope, proved to be actinomyces. In this case there was a mixed infection, namely, actinomycosis and the staphylococcus albus.

Wm. E. Morgan mentioned three cases of actinomycosis that had come under his observation in the last year or two. One was a case of appendical actinomycosis, which he was able to follow to the end, and obtained a very thorough post-mortem examination. Enormous doses of iodide of potassium, running the dosage up to 30 grains in twenty-four hours, and continuing not only for days, but weeks, without any apparent improvement. The man's anemia in this case made a deep impression upon him, and yet in examining the blood count he found it almost normal, at all times.

Edward H. Ochsner has had occasion to look up the literature of the subject, and found it very meagre on three of the most important points. First, wherever there is secondary infection, the prognosis is much worse; wherever there is a likelihood of repeated secondary infection, it is still worse. The second point is the necessity of interrupted iodide treatment. A third point is the importance of seeing that there are no abscesses which the blood current, containing the iodide of potassium solution, cannot get at.

D. W. Graham reported a case of **large fibroid tumor of the ovary**, and showed the specimen. He exhibited a **fibroma of the uterus**, and a peculiar feature in this case was the large and long cervix. The patient sought operation on account of profuse and persistent hemorrhages. He mentioned an interesting case of **sacculated bladder**. He showed an appendix, seven inches long, filled with pus, which was dilated as thick as the index finger. He also reported another case of **appendicitis**, which was complicated with **suppurative thrombo-phlebitis of the portal veins**, extending to the liver, and indirectly to the spleen. He exhibited a **large carbuncle**, which he had excised in its entirety. He believes in extirpating a carbuncle as completely as one would amputate a gangrenous appendix, a gangrenous finger or thumb.

Daniel N. Eisendrath reported a case of **left-sided subphrenic abscess**.

The Chicago Neurological and Chicago Medical Societies held a joint meeting December 10, 1902, President Wm. A. Evans in the chair.

Frank Billings delivered an address entitled

### The Changes in the Spinal Cord and Medulla in Pernicious Anemia.

**Causes.** Among other things, Dr. Billings said that our knowledge of the cause of pernicious anemia is not satisfactory. We recognize certain contributory factors and infer a condition of toxemia which has not been proved. The disease so frequently follows the infections, like syphilis, malaria, typhoid, la grippe, etc., that it is impossible to ascribe any specific relation to them. The disease occurs more frequently in women than in men. It may occur at any age, but it is more common in the fourth decade than at any other time in life. Intestinal parasites have been found present in the disease, especially the *bothriocephalus latus* and the *ankylostoma duodenale*.

The condition of profound anemia, with deformed red cells, the presence of fetal red cells in the circulating blood, the presence of an abnormal amount of iron in the liver, together with degenerative changes in the muscles and in the marrow of bone, is a reasonable hypothesis for the assumption of the presence of a circulating poison—a hemolytic toxin—as the fundamental cause of the disease. The source of the poison has been the subject of many theories.

It is not improbable from the evidence we have that pernicious anemia is due to some hemolytic toxin, but whether of bacterial or autogenetic origin we cannot at the present time definitely say.

**Symptoms.** The symptoms of pernicious anemia are chiefly those due to a profound anemia manifested by weakness, lessened endurance, with dizziness, dyspnea, palpitation of the heart, etc. In probably a large percentage of the cases the body weight is preserved. There is a tendency to subcutaneous, submucous, retinal and other hemorrhages. Gastro-intestinal disturbance is very commonly present, and especially diarrhea. The appetite is often poor or capricious. The disease is associated with nervous phenomena in the great majority of cases; usually, however, subjective in character. The spinal cord lesions, which are now recognized as occurring in a small percentage of the cases, may appear as one of the earliest manifestations of the disease, or they may occur late, and may be manifested slightly or not at all up to the time of death.

Dr. Billings gave an analysis of forty-one cases of pernicious anemia that he has seen during the last few years. The consensus of opinion is that the nervous lesions are due to a toxic agent, which is also responsible for the anemia when it is present. The fact that the lesion does not involve, as a rule, a whole neuron or system; that the trophic cell is usually not disturbed in either the cortex, the spinal gray or the posterior ganglion, and that the ultimate primary change is one of degeneration of the nerve fiber itself, speaks for the effect of some blood-circulating toxin. The fact, too, that the brunt of the lesion occurs in that part of the tracts involved farthest removed from the trophic center, where the nerve fiber is the least protected by its nutritive cell, is evidence of a toxic cause.

**Conclusions.** The conclusions which one may draw from a study of the subject are:

1. That there is a well-established relation of diffuse cord degeneration with pernicious anemia.

2. It seems probable that the hemolysis and the cord changes are due to the same toxin.

3. While the source of the toxin is unknown, the fact that gastro-intestinal disturbance is so common in the disease would lead one to suppose that it is of intestinal origin.

4. The diffuse degeneration of the spinal cord which occur in conditions without pernicious anemia do not appear to differ essentially from those of pernicious anemia.

5. It is possible that a common blood-circulating poison exists which may expend its force on the blood in one individual, on the nervous apparatus in another, and coincidentally on the blood and spinal cord in others.

Sydney Kuh said that the essayist, in speaking of the etiology of pernicious anemia, quoted the statistics of some foreign authorities based upon 270 cases of pernicious anemia. In these statistics the statement was made that of this number of patients 22.4 per cent had suffered from syphilis, and from this the conclusion was drawn that syphilis is a factor in the etiology of pernicious anemia, although not a very important one. This statement he believes is misleading. Erb and Kuhp, and himself, had tried to find how frequent syphilis is among patients in general, and it is quite remarkable to see how exactly the statistics of all three agree, the conclusion being that amongst the general average of patients between 22 and 23 per cent had been infected with syphilis.

There is no doubt that the toxic theory of the origin of this disease is by far the most plausible one. A variety of diseases can produce exactly similar lesions in the spinal cord to the various troubles mentioned by the essayist, as atheroma, pellagra, etc. He has seen one case in which the changes in degree and extent correspond very closely to what had been described and demonstrated. In this patient, who had syphilis of the spinal cord, the parenchymatous and interstitial changes seemed absolutely independent of the distinctly syphilitic changes, and he attributed them to the syphilitic toxins.

Maximilian Herzog said the essayist had confessed he is an adherent of the theory which attributes the changes in the cord to toxins. It is possible that is the case, but Dr. Herzog thinks it is not absolutely necessary to form that conclusion because secondary anemia never leads to such changes. Secondary anemias are never as severe as initial or primary anemias. Secondary anemias do not kill the patient; he dies from tuberculosis or from some other condition, but not from the anemia itself. He has never seen a secondary anemia like a primary anemia, with a blood count of 300,000. He thinks malnutrition is more responsible for the changes to the cord than the toxins.

E. R. Moras stated that from observation and reading, and from cases he had seen, he has come to the conclusion that the fundamental cause of pernicious anemia is a chemic poison which exists in a relative quantity in the blood



of probably every human individual or animal. The absolute quantity which goes to each individual is determined by the habits, environments and special occupation and diet. Chemical analysis demonstrates acid produced in those conditions which are analogous to those found in the blood and tissues of pernicious anemic patients is formic acid.

Archibald Church stated that about nine months ago he had under observation five cases of pernicious anemia with nervous manifestations. His notes show some eighteen cases. Three years ago he called attention to the fact that in some instances spastic conditions were present, and these very frequently terminated in flaccid paralysis. As the disease progresses, it takes on the type of an ascending myelitis. Paresthesia is sometimes followed by anesthesia, which sometimes is absent, or they come and go in the lower extremities. In at least two cases he had seen a band of paresthesia or hyperesthesia followed by anesthesia gradually approach the trunk and chest, reach the neck, and terminate in Landry's paralysis. He is convinced that in some instances the gray matter is seriously involved. Recently he has followed to a fatal termination a case in which the lower limbs at first in a spastic condition subsequently became flaccid and finally paralyzed, bed-sores developed, and the muscles of the trunk showed degeneration. Later on the muscles of the hand and forearm showed decided atrophy, with fibrillary degeneration.

A point of some importance in the clinical onset of this disorder is that the mental picture is somewhat peculiar, owing to the probable impoverishment of the nutrition of the brain. These patients often present eccentricities of character and temper; they have hallucinations of sight; very commonly they will misinterpret things; they see objects crawling over the wall or bed or in the air, and will describe them. Other symptoms were mentioned by the speaker. Cases with which he has come in contact have simulated three conditions, locomotor ataxia, multiple neuritis and myelitis.

The speaker spoke of the beneficial results following the use of injections of salt solution. E. F. Wells had told him of a case which he believes to be practically cured by the use of large injections of salt solution.

L. Harrison Mettler said that we are told that the nutritive centers are located in the posterior ganglia, and that the distal extremities of the nerves are in the spinal cord, away from this center, and both would be affected equally by such a universal cause as a toxin or malnutrition. If a high degree of degeneration and sclerosis, for instance, in Goll's column, is shown, the peripheral nerves would show a correspondingly severe degree of degeneration if the toxin and malnutritive theory is the proper exposition. He thinks the cases illustrated by the essayist show such a disease as Gowers has described, and it is not really an ataxic paraplegia. These cases fall under the general head of combined sclerosis. They are not strictly systemic conditions; they are not sclerosis or multiple myelitis, but they furnish a systematic arrangement; they corre-

spond to the motor and sensory tracts, more or less marked in different parts of the tracts. So he thinks we can call them degenerations, diffuse in character, systemic, and falling under the general head of the combined sclerosis.

Dr Billings, in closing the discussion, said his belief is that a bothriocephalus latus which will attack a red blood cell will not attack a tissue cell, but at present our knowledge of the blood conditions in these cases is in its infancy.

The clinical cases related by Dr. Church he has also seen, and in the original address which he delivered in Boston he added four other cases of the disease, dead and living. He has not been able to procure a post-mortem on those who were dead, but he gave their clinical histories. Dr. Church and he were together in at least one of these cases, and he observed it through most of its clinical course—the one he referred to as terminating like an ascending myelitis. In addition, the patient presented in her two years of illness a secondary anemia as marked as any he ever saw.

As to the influence of the trophic cell over the long fibers, and the resulting degeneration in the column of Goll and the lateral tracts in the cervical region, and not in the peripheral nerves, he could not answer the question. In two of the cases the peripheral nerves were examined; in one the tibial nerve; in one the ulnar nerve, and in another the sciatic nerve was examined, and they were found to be normal. In the records he has gone over, the peripheral nerves have been found normal.

He has tried all sorts of treatment, and from the first has used the one suggested by Dr. Church, and while in some instances it has been of benefit, it is his experience that the patient goes right on and dies, in spite of the normal salt solution in any amount injected into the cord. The only good influence it has is that it fills up the blood vessels. He does not think the portal circulation is improved very much, or the intestinal tract cleansed very much by washing out four or five feet of the colon and leaving the rest of the small intestine unaltered.

Chas. H. Lodor, Official Reporter.

The Chicago Medical Society met November 26, 1902, President Wm. A. Evans in the chair.

Emanuel Friend read a paper entitled **Hygroma and Fibroma of the Tuber Ischii Bursae**. From a thorough search of the literature on this subject, he concludes, after reporting two cases, that these are the first reported in America. The rare occurrence of this affection is probably due to the inconstancy of this particular bursa, and from its location little liability of injury, due to the protection afforded by the gluteal muscles.

With reference to the etiology, trauma and long-continued irritation were important factors, especially in those vocations requiring the sitting posture, one of his cases occurring in a patient who had been in the saddle more or less for twenty years.

Relative to the pathology, the size of the



bursa removed was that of a large apple, the sacs of which were immensely hypertrophied, and in parts so much as to simulate true fibroma. One contained a teacupful of rice bodies, the other a bloody sero-sanguinolent fluid. The microscopic picture, detailed more minutely in the text and drawings, showed a typical hemorrhagic infiltration. The rice bodies were decidedly non-tuberculous.

The treatment was that of excision of the bursae in their entirety from off the tuber ischii.

Daniel N. Eisendrath has had occasion to see several cases of disease of the bursae. One of them was the bursa situated at the back of the knee, under the semi-membranosus tendon, simulating very much an enlarged lymph gland at the back of the knee. He mentioned four cases of inflammation of this bursa.

#### **Preliminary Report Concerning the Power of Certain Human Organs to Destroy Uric Acid.**

The author of this paper, Alfred C. Croftan, called attention to the fact that two perversions of the uric acid chemism may be considered typical and fairly constant of the uric acid diathesis, namely, first, that the uric acid in the blood is increased in amount and, second, there is a tendency in this diathesis to the deposit of crystalline sodium urate in certain points of predilection. The second factor may be considered in a sense dependent on the first one, for it is probable that urate concretions can only be deposited if the uric acid in the blood is increased above normal. Any attempt, therefore, to understand the cause of the uric acid diathesis, and any endeavor to treat this disease must be directed towards understanding the factors that determine the accumulation of uric acid, and towards preventing this accumulation or reducing it after it has once occurred.

The accumulation of uric acid in the blood may manifestly be due to one of three causes, or to several of these causes combined, namely, first, there may be excessive formation of uric acid; second, there may be retention of uric acid; third, there may be deficient destruction of uric acid.

The speaker referred to previous work and to investigations concerning the increased formation and the retention of uric acid in the blood, and announced that he would limit his discussion to the elucidation of the third factor alone.

In order to understand the pathology of a disease, it is necessary to understand the function or functions, the perversion of which it represents. In this concrete case it is necessary, therefore, to determine whether uric acid is normally destroyed in the mammalian organism before we can undertake to explain certain features of the uric acid diathesis by assuming a perversion of this function.

The essayist then proceeded to recount briefly some of the experiments that he has performed in order to determine, first, whether uric acid was normally destroyed in the animal organism; second, where it was destroyed, and

third, what became of it. The main results of the experiments are the following: The administration of uric acid by mouth to human subjects or to animals leads to the excretion in the urine of only a small proportion of the uric acid that is ingested. In order that experiments of this character may be considered valid, it is essential that the subject or the animal be placed on a diet that is altogether free from uric acid or from uric acid-forming substances (purin bodies). The results of these experiments, while positive, are ambiguous, for there are many possible sources of error. We do not know positively, for instance, whether uric acid is absorbed from the intestine, or whether it is destroyed by the bacteria of the gastro-intestinal tract, or by the action of the gastro-intestinal secretions.

Comparative estimates of the ingestion of the output of vitogen give doubtful results.

Another difficulty in performing experiments of this kind in animals, especially in rabbits, is to collect the urine quantitatively. For instance, rabbits only pass about five c.c. of viscid urine every hour that is loaded with phosphate, and it is manifestly a difficult matter to obtain all of this. Small errors, moreover, when calculated in so little urine become proportionately large. With the aid, however, of a mixture of salts that possesses great diuretic powers (the formula for this diuretic mixture was kindly placed at the disposal of the author by S. A. Matthews), it is possible to stimulate the flow of urine to a remarkable extent in rabbits, so that these animals pass as much as 100 to 150 c.c. of urine in an hour, the specific gravity of the urine passed being occasionally lower than the specific gravity of the salt solution injected. By adding uric acid in alkaline solution to this diuretic solution it is possible to force uric acid through the animal in a very short time, and it was determined that in the passage through the body over 85 per cent of the uric acid was destroyed. The author then proceeded to describe the details of the intravenous method of stimulating diuresis and to give some animal protocols to substantiate his position.

He then described some experiments with organ extracts in the lower animals and in human beings. The results in human beings show that extracts made from the liver, the kidneys, and the muscles possess uric acid-destroying power, and that uric acid is converted into urea by their action. Watery extracts of these organs, mixed with sodium urate solution, and placed in the incubator for varying periods of time, produced a progressive loss of uric acid. The action of bacteria and the oxidizing action of the air were excluded by control experiments. Boiling seems to destroy the power of these extracts. The kidneys seem to possess relatively the greatest uric acid-destroying power; next the liver, and, last, the muscles. The author called attention to the clinical significance of the former findings, showing apparently that the amount of uric acid excreted gives only a relative index of the amount of uric acid circulated in the blood. He said that it represented, so to say, the al-

gebraic sum of the uric acid formed, and the uric acid secondarily destroyed in the kidneys and the other organs. Uric acid must, therefore, be considered not a terminal product of metabolism, but merely an intermediary product.

Dr Croftan, in conclusion, made some suggestions in regard to the use of a ferment-like ("oxidase") body that he has succeeded in isolating from these organ extracts. He called attention to the possibility of reducing the accumulation of uric acid in the blood, and in this way, at least symptomatically, attempting to counteract one of the most typical perversions of the uric acid diathesis.

Norval H. Pierce reported a case of **abscess of the temporal lobe and of the occipital lobe, together with thrombosis of the lateral and sigmoid sinuses, from chronic middle ear suppuration.** There was rupture of the abscess of the temporal lobe into the lateral ventricle. He exhibited the brain and temporal bone.

In the discussion, L. Harrison Mettler reported the case of a woman, fifty years of age, who came under the observation of Dr. Lovewell for a short time, passed into a condition of coma, when the speaker was invited to see her. Seventeen years previously she had an attack of acute otitis media. Off and on during that time she had exacerbations of discharge from the ear, and with it certain mental symptoms, as irritability, intermittent headache, melancholia, complete loss of mental faculties, so that she was sent to an asylum for the insane, and when she recovered was dismissed. He is not prepared to say that the abscess of the brain lasted seventeen years, but he thinks the ear trouble did last that length of time. Among the other symptoms were ptosis, diplopia, and the condition of the urine. The urine contained albumin, hyaline and granular casts, one and a half per cent of urea, with a specific gravity of 1030. There were no convulsive movements. The coma was not complete. An unfavorable prognosis was given. The patient died the next day. No autopsy was obtained.

He called attention to this case from the standpoint of the differential diagnosis between cerebral abscess and uremia.

J. Holinger said in the last year the following cases of intracranial complications of chronic suppurations of the middle ear have come under his observation: One case of abscess of the temporal lobe; four cases of thrombophlebitis of the lateral sinus; and two cases of meningitis, a short report of one of which shows one interesting feature. A man, baker by trade, came walking to the Alexian Brothers' Hospital, complaining of headache and a running ear. He saw him the same evening, and found him dying. He thinks many lives can be saved without operative intervention by timely treatment.

Carl Wagner detailed three interesting cases of brain abscess, and discussed the condition of the pulse in such cases.

R. M. Parker cited a case of a girl with brain abscess, who was thirteen years of age,

and gave a previous history of chronic ear trouble.

#### Albugineotomy in Chronic Orchitis.

Emanuel J. Senn read a paper on this subject. He said the surgeon frequently encounters cases of chronic orchitis, either the result of a hematogenous inflammation, a specific infection from the urethra, or of traumatic origin. These cases are chronic in their course, and often baffle conscientious conservative treatment.

The following case illustrates the value of albugineotomy, as this operation was performed instead of castration:

W. E. D., aged 27, American, single. Patient had diseases of childhood; gonorrhea at the age of 18; one year later a supposed soft chancre. During the year 1898 he had malaria and measles while serving in the Spanish-American war. During February, 1902, without any apparent cause, the right testicle became enlarged and tender. He consulted a physician, who made some local applications, when the testicle diminished to its normal size, and the tenderness left. On May 1st, the testicle again became enlarged and tender. All palliative measures failed to give relief, and he entered the medical service of the Presbyterian Hospital on May 14th. The right testicle was found to be enlarged three times the size of its fellow, and was exquisitely tender to the touch. No discharge from the urethra. The patient was placed in the recumbent position and hot moist compresses were applied locally. His doubtful previous syphilitic history was taken into consideration. He was placed upon increasing doses of iodide of potassium, but no benefit whatever was secured from this treatment. The pain was greatly increased upon walking, which prevented him from leaving his bed. Patient next underwent X-ray treatment, with no amelioration of symptoms being manifest. A malarial orchitis was next thought of, but repeated examinations of the blood proved negative. Patient was then transferred to the surgical service for castration, a probable diagnosis of sarcoma having been made. The clinical history, however, to the mind of the essayist, pointed to an inflammatory origin of the disease, and he resolved to do an albugineotomy.

#### Operation.

August 26, 1902, an incision was made in the scrotum. No fluid found in the cavity of the tunica vaginalis. The testicle was greatly enlarged, pyriform in shape, and elastic to the touch. The envelopes of the testicle were firmly adherent and under great tension. The epididymis was slightly enlarged, and the vessels on its surface congested. The tunica albuginea was incised on the convex surface of the testicle from pole to pole, and the margins of the wound were mobilized from the subjacent structures for a distance of a quarter of an inch. The wound surface was an inch wide in the central part of the incision. A small portion of the cortical substance was removed for examination. After cleansing the

parts with normal salt solution the testicle was dropped back into the scrotum, and the external wound closed. Relief from pain, which had been constant for four months, followed immediately after the operation. Subsequent examination of the testicle five days after the operation showed it reduced to its normal size, and painless. There were firm adhesions between the denuded surface of the testicle and the parietal layer of the tunica vaginalis. The patient was allowed to leave his bed on the seventh day, and was discharged from the hospital on September 13, 1902.

The benefit derived from this operation was summarized as: "1. Relief of tension; 2. Direct drainage of the intercellular spaces, and 3. resolution of primary pathological products."

The author believes that castration is too frequently performed. Albugineotomy should be first given a trial, and will be successful in the majority of cases, provided degenerative changes have not destroyed the entire integrity of the organ.

The Chicago Medical Society met December 3, 1902, President Wm. A. Evans in the chair. Otto J. Stein read a paper entitled **Sclerosis of the Mastoid Process.**

I am prompted in presenting the history of the following cases by reading the report of a case of morphomania with extravagant claims of aural disease read by Francis W. Alter, of Toledo, Ohio, before the Lucas County, Toledo, Ohio, Medical Society, December, 1901.

Before proceeding with my cases I will in brief give you the history of Dr. Alter's case.

The patient, a woman of 36 years, first complained of a fullness and some pain in the right ear three or four years previously to the present time. After being treated with more or less success by several physicians she took the advice of some friends, and began the use of morphine by the hypodermic method, and when seen by Dr. Alter she was taking one and a half grain of the drug every four hours. The patient complained very much of her ear, the mastoid process particularly being exquisitely tender so as to deprive her of much sleep. Objectively the ear presented "slight evidences of otitis media catarrhalis chronica." "In the inferior and middle portions of the membrana tympani was to be seen a calcareous deposit. This, together with a history of arthritic disturbances, suggested a gouty diathesis, for which citrate of lithia was given." In the treatment, bromide of sodium "in goodly size doses with tonics and one twelfth grain doses of heroin every four hours" were employed as a substitute for the morphine. After leaving the hospital she was in "fairly good health and spirits," although at the time of preparing his paper he says she had a relapse. Alter sums up his paper with the following conclusions: First, that the patient had a desire to satiate the craving for the drug; and secondly, she had the desire to create a seemingly valid reason to those about and to herself to a right to employ the drug.

I would now ask you to notice the similar-

ity in the history of this case and the first one I wish to report.

Miss B., age 36 years, sent for me January 13, 1902, for the relief of an ear trouble on the right side, which resolved itself mainly into the symptoms of pain and fullness. Although I personally saw the case at this time, there were, upon ocular examination, no symptoms indicative of acute middle ear inflammation. She complained of intermittent pains deeply seated in the right ear, and a more or less dull ache continuously. A sense of fullness with slightly impaired hearing were also complained of. The nose and throat examination was negative. Her temperature was normal.

I saw the patient at my office March 20th, two months afterwards. She claimed not to have been entirely free from pain in her ear ever since my first seeing her. I now gave the case a thorough examination, carefully analyzing the subjective symptoms and the objective findings in the light of her previous history. In order to be brief I shall only give a summary of my examination.

Personal history. A subject of digestive disturbances for years; has eructation of gas to such an extent as to attract embarrassing attention of all who may be about; constipated, as the average woman is; has what one may call a neurotic temperament. Her teeth, although in very fair condition, exhibited a deposit of tartar that for quantity and quality was indeed something astonishing to behold in a lady of her quality. She sleeps very poorly; has had rheumatism.

Subjective symptoms. Suffers from severe pain, amounting to that of neuralgia, within the ear and mastoid process. The severe pains subside at times to a dull ache that seems to be continuous, having been so now for over two months; slight involvement of hearing caused by a sense of fullness in the ear; no tinnitus.

Objective findings. Tenderness on firm pressure over the mastoid area. Learned nothing from auscultation of the mastoid. Skin and tissues over mastoid region normal in appearance. The drum membrane was not even congested, but in its posterior inferior quadrant was to be seen a large calcareous deposit. Another smaller one was toward the center. The position of the drum was slightly exaggerated in the concave. The shadow of the tip of the incus could be seen. The eustachian tube was patent to inflation. The temperature registered 99.5 F. The pulse was regular, but feeble, and counted 88. The urine showed alkalinity on the first examination but later was neutral.

Functional examination. Rinne, positive; Weber, negative, Celle positive. The capital C tuning fork was heard 10.25 (Rinne positive). The capital C<sup>4</sup> fork was heard 0.8. The c fork was heard 0.8. Galton whistle heard through its entire scale. Inflation has no influence on the hearing.

To relieve the pain and get some sleep the patient has been an habituate to the use of "Bromo-Caffein," so that dozen upon dozen of



empty bottles of the drug have been removed from her room at short intervals. Aside from this kindred other "quieting powders" were constantly used. Most of these were proprietary preparations which taken in the quantities used by her could not help but prove injurious. She told me that she could not live without the use of something or other to relieve her head pains and quiet her sufficiently so as to get some sleep at night.

The patient was under observation for several weeks, during which time her teeth were first ordered to be attended to. A stomachic tonic containing dilute hydrochloric acid, nuxvomica, black pepper and gentian was employed. Besides bromides, largely diluted with great quantities of water, were given for the pain. In addition the diet was regulated so as to eliminate as much as possible the nitrogenous elements, and a five grain lithia tablet was ordered taken with each meal. Electric massage, with the addition of physical exercise was given her.

Eight weeks of this treatment proved of some little benefit, but still the pain was in that side of the head. At the very outset the patient was made aware of her condition by my explaining the pathology present. I told her I believed the process was one of osteosclerosis, and as is so frequently the case during the hardening process, the patient suffers severely from neuralgic pains. I told her that as a last resort we might trephine the bone and relieve the tension within and thereby the existing pain. This was at last done. The entire mastoid process operated upon was found as dense and hard as ebony. Almost immediately after the operation the severe pains disappeared entirely and have not recurred.

I have a similar case under observation now, only she has not been operated as yet.

The second case I wish to report was one occurring in a young lady of about 24 years of age. Her trouble originated as an acute otitis media on the left side, which terminated in a suppuration with perforation of the drum membrane. The suppurative symptoms soon subsided and the drum head healed. Shortly following this she complained of neuralgic pains in the left mastoid process, radiating over the entire side of the head, back of neck and even into the eyes. In spite of all attempts to relieve her suffering the condition continued for a couple of months, when I finally decided to perform a mastoid operation. In this case, as in the one just reported, the mastoid process was very hard and devoid of any cells. The pain in this case disappeared shortly after the operation.

Owing to an absence of a sequence of symptoms that point definitely to decided pathologic changes within the temporal bone, it has been presumed that a positive statement as to the presence of an osteo-sclerosis of the mastoid process is difficult. It is true that in establishing a diagnosis in such cases we are confronted at the very first with a lack of an array of symptoms characteristic of the condition. But this very lack of definite ear

symptoms is really an aid to the establishment of a positive opinion.

When pain is present it is the all important symptom, and it must be studied very carefully in order to exclude other possible causes. As for instance the imaginary pain of hysteria, the pain of lithemia, gout and rheumatism; chronic abscess of the bone; cholesteatoma of the mastoid process, and the reflex neuralgias.

Observers and writers on ear diseases, years ago, recognized the cause of pain in connection with the hardening process of the mastoid. Bruhl says "while the process of osteosclerosis is going on the patient may complain of neuralgia." All the older writers reported the prominence of pain as a symptom in connection with hardening of the mastoid process.

Possibly the malingerer and the hysterical subject are the two possible sources of mistake, in neither of which would it require more than the suggestion of an operation as the remedy to be employed, to cause them to declare a sudden and marked improvement in their condition.

The pain in osteo-sclerosis of the mastoid process is very deep seated. My patients express it as "away down deep in the ear." A dull ache, similar to a slight tooth ache is constantly present. At intervals the pain increases to the extent of being neuralgic in character. It is centered mainly back of the ear, in the mastoid region, and thence radiates up towards the side of the head and down into the neck. At times there is an associated occipital headache. I have never heard them complain of pain in front of the ear.

This condition continues to persist day after day, week after week and month after month, often bringing the patient to a state of mental as well as physical exhaustion. To relieve this persistent, intense and often intolerable suffering they most naturally take recourse to remedies that tend to relieve their agony; and from a simple sedative they are gradually lead to use the stronger ones, until even the more powerful and dangerous hypnotics and analgesics relieve their suffering but temporary. Is it any wonder that such patients fall just as easy prey to the use of injurious drugs?

In addition to the pain just described, one will always find a spot over the mastoid process which, when pressed upon will elicit a sharp sensation of pain. This spot is usually found on a line with the meatus. Although the tenderness may not be limited to this region, but at times may extend over quite a large area. The auricle, the integument lining the auditory canal, the region in front of the tragus and just beneath the lobe of the ear are not at all sensitive to the touch. In this we have a difference between the hyperaesthesia of these parts noticed in hysteria and the malingerer. In reflex neuralgia the pain can usually be traced along some particular nerve to the origin of the trouble.

My cases have all shown a slight rise in

temperature, 99 to 100 degrees F., at times during my observation.

Very frequently the history of previous ear disease, either a catarrhal or a suppurative variety, is given, and at times evidences of such may be found in the form of perforation of the drum membrane with pus, adhesions of the drum membrane, cicatrices, atrophic spots or calcareous deposits.

In some cases transillumination and auscultation of the mastoid process might be an aid in the diagnosis, although I myself do not place much reliance upon them.

In addition to the pain as a symptom of this condition, the importance of the operative measure in rendering relief is what I want to lay particular emphasis upon.

Dr. Kapp, in a paper read before the 20th annual meeting of the American Otological Society, in 1884, on the Indications for Opening the Mastoid Process, says, "In sub-acute or chronic sclerosing non-suppurating mastoiditis with an intact drum membrane, the mastoid may be opened when cerebral symptoms are present, or especially intense and obstinate pain, radiating from the mastoid over the whole side of the head, incapacitating the patient from work."

The opening of the mastoid for the relief of this condition has been done on several occasions, but it is not a common procedure. Dr. Knapp first performed it in 1881 (Archives of Otology, Vol. 10, page 365), on a girl of 16 years, with no symptom of ear inflammation at any time, excepting an excruciating pain centered in the left mastoid process, and which was relieved immediately and entirely by opening the mastoid.

Cases are known where the process has been opened by mistake, that is a mistake in the diagnosis, where the operator thought he had to do with an abscess condition, but on opening the parts they found nothing but hard and dense bone. But to their astonishment their patients got entirely well.

M. H. Cryer, in his recent book entitled *Studies of the Internal Anatomy of the Face*, says, apropos of facial neuralgia, that secondary bone deposit of inflammatory origin in the cortical or cancellated tissues of the face is an important factor in producing facial neuralgia.

The particular operation performed in this class of cases is a simple one and scarcely ever need require more than the removal of a large core of bone just posterior to the meatus. It may not even require the exposure of the mastoid antrum. The operation is best done with an instrument that will leave a clean and smooth surface, and in my hands I have found nothing better for this purpose than an instrument known as the Russian Perforator. With this instrument you remove a core of bone about the size required; you have perfect control of the instrument and of the parts you are working in, so that there is no danger of injuring any of the important neighboring structures; you have a surface that is free from

irregularities and spiculae of bone, thus favoring a rapid healing by first intention.

Norval H. Pierce said that if there is such a thing as a primary sclerosis of the process of the mastoid which causes symptoms of unendurable pain sufficient to force an individual to take morphine, etc., it adds a great deal to the difficulty in diagnosing the various well-known pathological conditions of the mastoid. The literature does not give any reason for believing that there is such a primary sclerosing change of the mastoid. There is such a thing as sclerosing osteitis in the mastoid, but this always follows a suppurative process in the antrum and the cells in juxtaposition to the antrum. It is the same process that is found in other bones of like structure as the mastoid. Therefore, one should be careful in accepting the conclusion of the essayist, inasmuch as it would be difficult to differentiate between this condition and true hysteria.

Wm. L. Ballenger believes that there are cases of sclerosis of the mastoid attended by pain, but does not think that they are primary, that is, he does not believe a sclerosis of the mastoid exists previous to a suppurative process. He agrees with Dr. Pierce in that regard. He did not understand Dr. Stein to claim that these cases of sclerosis of the mastoid were primary, but that they might present with marked evidences at the time of the middle ear disease. In dealing with these cases, one should differentiate between the neurasthenic cases, referred to, and a central mastoiditis, that is, a mastoiditis limited to the center of the mastoid process, without any extensive degenerative changes in the mastoid in general.

Henry Gradle said that a mastoid operation is altogether too large to undertake without positive indications. If suppurative disease of the mastoid is suspected, one might be justified in operating, but where this can be excluded, it does not seem prudent to operate, as operative procedure might result in accidental complications in the hands of the best operators.

Dr. Stein, in closing the discussion, said that he did not state whether this is a primary or secondary condition. He is fully aware that the tissues are such as to lead one to think that the condition is essentially secondary, but he did not presume to answer the question definitely whether it is primary or secondary.

### Splenectomy.

J. Clarence Webster reported a case. The patient's family history was quite negative. She was thirty-seven years of age, and gave a history of repeated attacks of malaria during her residence in the South of many years. Twice she was jaundiced, and on two occasions had a severe pulmonary hemorrhage. Twenty-six years ago she had an attack of typhoid fever, and when a child was the subject of rheumatism. Her present illness dates back seventeen years, when she observed after the birth of her child a swelling in the right iliac region, which was quite painful, and of slow growth. Four years ago she was laparotom-



ized, and the operator told her that he found an inoperable tumor connected with her right kidney. When seen by Dr Webster during the summer, she complained of severe pain in the abdomen, chest, shoulder, and the right iliac region. Dysmenorrhea and frequent and painful micturition were prominent symptoms. She was very short of breath. For the past eight years she had very severe colicky pains in the right side, which at times were so intense as to demand the administration of chloroform. After the subsidence of these colicky pains, her urine was very dark and of a reddish-brown color, and of strong odor.

Physical examination revealed an emaciated and sickly-looking woman, whose skin was intensely pigmented. The pigmentation was of a brownish color, diffused over the entire body, with here and there patches of intenser color. There were in and on the skin innumerable nodules.

Examination of her blood showed 4,016,000 red cells; 16,800 whites, and 70 per cent hemoglobin. Her temperature for the most part was slightly above normal, from 99° to 101°.

Bimanual vaginal examination revealed a fixed and retroverted uterus, with appendages not distinctly palpable, but fixed and tender, and close to the right side of the uterus, extending to the ilium, and completely filling the right iliac fossa was a large movable tumor.

Examination of the bladder by the Kelly method was negative save a congested area behind the trigone. Catheterization of the ureters revealed a constriction of the right ureter three inches above the bladder orifice, which could be passed with a catheter. The urine obtained from the right ureter contained some blood, 1.3 per cent of urea, and, microscopically, contained some small squamous and cuboidal cells, with a few hyaline and blood casts. The urine from the left kidney contained no blood or cellular elements, urea 1.7 per cent, and the quantity that was voided during the period that the catheters were left in the ureters (one hour and fifteen minutes) was three and one-half times greater than on the right side.

After treating the patient for a few months on tonics, she was operated upon on the twenty-fifth of September, and a large tumor, which was enveloped in dense adhesions, which was fixed to the brim of the pelvis, adherent to the uterus and its appendages, to the bladder, and also the vermiform appendix, was removed. This tumor was found to be a greatly enlarged spleen. The patient made a very satisfactory recovery, and was exhibited by Dr. Webster to the members.

Microscopic sections of the spleen and the cutaneous nodules were exhibited.

#### Charles B. Reed reported an interesting Case of Funnel Pelvis.

May 4, 1900, he was called in consultation to see a patient, aged 19, in her first confinement. In spite of the utmost efforts attempts to effect the delivery failed. The child was asphyxiated, craniotomy was done through the roof of the mouth, and the mutilated head

passed the contracted outlet with some difficulty. In October, 1901, she reappeared, pregnant for the second time, but with no knowledge of the date of conception. This time it was found necessary to resort to Cesarean section to extract the child. The child weighed seven and one-half pounds, and at the end of four weeks the mother left the hospital with her babe in excellent condition.

Rudolph W. Holmes thinks that cases of funnel pelvis, taking all types, are not so infrequent as has been generally believed. A case of absolutely typical funnel pelvis, with a normal brim and contracted outlet, is very infrequent. The most frequent type of funnel pelvis is the generally contracted one, with contraction most marked at the outlet.

Dr. Reed, in closing the discussion, said that forceps are most frequently used in these cases as a means of terminating labor after the head is engaged, and failure with forceps means craniotomy, and success with the forceps might mean extensive lacerations of the soft parts of the mother, with the usual results.

#### The Relation of Gonorrhea to Tuberculosis of the Genito-Urinary Tract in the Male and Female.

Daniel N. Eisendrath read a paper on this subject, in which, after presenting a study of the cases found in the literature and in his own practice, he drew the following conclusions:

1. That in patients suffering from an acute gonorrhea there may be an almost imperceptible transition into a malignant type of tuberculosis.

2. That subacute or chronic gonorrhea may mask the presence of a tuberculosis. That these, as well as the acute form, may act as predisposing and, at times, as exciting causes of tuberculosis.

3. In patients who show evidence of local complications of gonorrhea, such as prostatitis, vesiculitis, cystitis or epididymitis, one should always bear in mind the possibility of tuberculosis and examine the urine for tubercle bacilli, if anti-gonorrheal treatment causes no improvement.

4. In patients with marked tubercular history, an attack of gonorrhea should be carefully watched, and the prognosis be guarded.

5. Gonorrhea, both in the male and female, often prepares the soil for later invasion of the tubercle bacillus.

A. J. Ochsner said not enough attention has been given the matter of gonorrheal infection in its relation to tuberculosis of the genito-urinary tract. His attention was first directed to this subject by the investigations of Hunter Robb, of Cleveland, who found, in a very large percentage of cases, infection of the tubes, which, in their gross appearance, seemed to be purely gonorrheal in origin.

G. Frank Lydston said the subject was perhaps of more importance than had usually been ascribed to it. He does not think anyone will deny the fact that any severe acute inflammation of structures so important as the genito-urinary tract, especially any chronic inflammation of that portion of the anatomy, will serve as a possible predisposing or excit-



ing cause of tubercular infection. The subject has been brought forcibly to his attention by a moderate number of cases extending over a long period. He believes, however, that if gonorrhea is a powerful exciting or predisposing cause of tuberculosis, or so important as the essayist seems to believe, the profession would have a tremendous number of cases to treat of apparently primary tuberculosis of the genito-urinary tract, and that portion of the genito-urinary tract which is most severely affected, the distal portion, should exhibit quite a number of cases of primary tuberculosis, but, as a matter of fact, these cases are exceedingly rare.

Charles S. Bacon thinks the importance of gonorrhea in the production of tuberculosis of the male and female genito-urinary tract is coming to be recognized. The frequency of tuberculosis of the tubes is well-known. It is reasonable to suppose that this frequent involvement of the tubes, which also often occurs without any implication of the peritoneum, may be due to a previous gonorrheal inflammation. The use of the term primary tuberculosis is misleading. He does not understand Dr. Eisendrath to imply that there was primary tuberculosis, but secondary tuberculosis, that develops in this region as the result of gonorrhea.

F. Kreissl expected to hear the essayist mention the simultaneous primary infection of the genito-urinary tract with gonorrhea and tuberculosis, of which several well observed cases are on record, and he, personally, has seen a few. The author deserves credit for calling attention to the fact that gonorrhea and tuberculosis of the genito-urinary tract may co-exist, and that the tuberculosis may be the real cause of the trouble. Adenitis, epididymitis and prostatitis, of the type described, ought to arouse suspicion and call for more careful investigation. Inasmuch as primary tuberculosis of the genito-urinary tract is comparatively rare, and its early detection still more infrequent, the well-known relation between this disease and gonorrhea ought to be a valuable auxiliary means in a possible early diagnosis and radical treatment.

Dr. Eisendrath, in closing the discussion, said the relation between tuberculosis and gonorrhea shows that this subject is beginning to receive more attention than it has in the past.

The following new members have been admitted. Addresses are always in Chicago unless otherwise stated.

Albro, M. Z., 1471-35th st.  
Burchmore, John H., 2607 Prairie ave., Evanston.  
Boot, G. M., 1945 Maple ave., Evanston.  
Baldridge, 3628 Halsted st.  
Bell, George, 1410-35th st.  
Bassoe, Peter, Presbyterian Hospital.  
Balderston, S. Victor, 1578 Chicago ave.  
Cornelius, Max C., 691 E. 47th st.  
Clark, Tracy H., 2535 Hermitage ave.  
Dornbusch, H. W., 1038 N. 42d ave.  
Espy, Charles W., 1192 Armitage ave.  
Flint, Nellie C., 749 Marshall Field Annex.  
Hinch, M. Agnes, Dunning.

Hillis, David S., 6303 Monroe ave.  
Harder, H. P., 707 Main st., Evanston.  
Hamisfer, Florence N., 330 LaSalle ave.  
Hunt, Rodney, 234 S. Boulevard, Oak Park.  
Hemenway, H. B., 1744 Chicago ave., Evanston.  
Hemingway, C. E., 439 N. Oak Park ave., Oak Park.  
Harding, P. D., 602 Davis st., Evanston.  
Illingworth, G. M., 161 North ave.  
Knight, E. C., 92-905 State st.  
Kimmet, William A., 1022 N. Halsted st.  
Kanavel, Allen B., 58th and Calumet ave.  
Kerlin, E. Iles, 576 Fullerton ave.  
Klein, Henry, 1152 Lincoln ave.  
Kelly, Joseph A., 430 E. 35th st.  
Kaufmann, G. W., 815 Chicago ave., Evanston.  
Lewis, W. R., 120 Maple ave., Oak Park.  
Lespinasse, V. D., Cook County Hospital.  
Landis, E. M., 1115 N. Clark st.  
Mars, Mary, Dunning.  
Mefford, W. T., 882 W. Madison st.  
Mikolosek, Jan F., 1900-47th st.  
Mitchell, Louis J., 65 Randolph st.  
McGonagle, T. C., 5504 Halsted st.  
MacLay, Otis H., N. E. Cor. 63d and Cottage Grove.  
Miller, Charles, Hotel Mentone.  
Mueller, Frank Louis, 59 W. Foster ave.  
O'Connell, Richard J., 1901 Milwaukee ave.  
Parsons, William, 841 W. 47th st.  
Porter, Mary O'Brien, 1412 Jackson Blvd.  
Pischczak, John, 4725 S. Ashland ave.  
Pitkin, Alice F., 550 Wilson ave., Ravenswood.  
Roach, J. J., 5158 Princeton ave.  
Sweeney, John L., 357 W. 47th st.  
Selby, Emily H., 235 Michigan ave.  
Storck, William, 5504 Monroe ave.  
Seapy, John A., 1454 Odgen ave.  
Wells, W. H., 1820 N. Clark st.  
Wachowski, J. G., 4647 S. Ashland ave.  
Will, Harry C., 1296 Ravenswood Park.

The Ravenswood branch of **The Chicago Medical Society** held its first meeting Tuesday, December 16, 1902, with an attendance of thirty-five. A permanent branch was established, officers elected and a constitution adopted.

The call to establish a North Side branch of **The Chicago Medical Society**, on December 11, 1902, at the Chicago Academy of Sciences, to which 56 responded, resulted in the establishment of a permanent organization and the election of officers. Drs. Evans and Preble discussed the merits of branch societies, in which the members joined. Meetings are to be held on the second Thursday of every month at the Chicago Academy of Sciences, North Clark and Center streets. The hours as agreed on are from 8:30 P. M. to 10:30 P. M. Henry G. Anthony was elected president, W. D. Storer first vice president, and Mortimer Frank secretary and treasurer.

The **North Shore Medical Society** held its first regular meeting on Tuesday evening, December 16th, at the Ravenswood Club House. Alben Young presided as temporary chairman. The meeting was called to order. Minutes of a previous meeting of members of the Chicago

Medical Society residing in this district for purpose of organizing this society, were read and approved. The report of the committee appointed to draft constitution and by-laws was read and adopted. The substance of the report was the presentation of resolutions and rules to govern the society until the adoption of the new constitution by the Chicago Medical Society. The following temporary officers were elected to act also as a committee to arrange for subsequent meetings until the adoption of such constitution, when they should become permanent officers: Maximilian Herzog, chairman; Alben Young, vice chairman; George Edwin Baxter, secretary and treasurer. A committee of organization—G. W. Green, for the Ravenswood district; Bertha E. Bush, for the Rogers Park district; George L. Chapman, for the Sheridan and Buena Park district. The secretary then read a communication from Carl E. Black urging the members of the profession to respond to the call to aid the Legislative Committee in its work. Supper was served after which W. A. Evans gave a interesting talk on the purposes and merits of organization. Regular meetings will be held the first Tuesday of each month. About thirty were present.

George Edwin Baxter, Official Reporter.

The Physicians' Club of Chicago held its regular meeting at the Sherman House, Monday, November 24, 1902. Frank B. Earle acted as chairman. The subject was

#### Child Labor.

The papers printed below in full were read and discussed.

E. D. Howland, 103 State street; S. R. Slaymaker, 100 State street; Arthur J. Behrendt, 93 Fowler street, and M. R. Barker, 4625 Greenwood avenue, applied for membership.

#### EXTENT OF CHILD LABOR.

By Mr. Edgar T. Davies, Chief State Factory Inspector of Illinois.

The extent and nature of the employment of children is well indicated by the State Factory and Labor Reports, and by the reports of the United States Department of Labor. It is everywhere and conclusively shown that those states which have restricted the employment of children to certain ages have thereby lessened the total number employed. This is in marked contrast with those states which have no such enactment. In these latter the increase in the number of children employed is striking. Statistics show in South Carolina that 10.25 per cent of all the working people were children under fifteen years of age, and in North Carolina the number of such children reached 14.10 per cent of the total. The census figures for those states that have enacted child-labor laws were in no case greater than 3.07 per cent, but at the same time there has everywhere been shown a natural tendency of child-labor to increase faster than the population, except at those times and places where

it has been temporarily checked by adverse legislation.

#### United States census report:

1900 .....	168,623
1890 .....	120,885
1880 .....	181,921
1870 .....	114,628

—1900—

	Children under 16 years.
Georgia .....	6,373
Illinois .....	10,419
Maryland .....	5,884
Massachusetts .....	12,556
Missouri .....	4,510
New Jersey .....	8,042
New York .....	13,189
North Carolina .....	10,377
Ohio .....	4,369
Pennsylvania .....	33,135
Rhode Island .....	5,036
South Carolina .....	8,560
Virginia .....	4,164
Wisconsin .....	5,679

In Illinois a greater proportion of all the children over fourteen years of age in the state is annually employed in her industries and mercantile institutions. The total since 1893 is as follows:

Year.	No. of inspections .....	No. employees found at work.....	No. of children .....	Percent of children to No. of inspection	Percent of children to total number of employees.
1893 .....	2,362	76,224	6,456	273	8.5
1894 .....	3,440	130,065	8,130	236	6.2
1895 .....	4,540	190,369	8,624	189	4.5
1896 .....	6,707	200,140	7,340	108	3.6
1897 .....	11,703	270,271	9,259	79	3.4
1898 .....	10,797	351,057	11,845	109	3.3
1899 .....	15,575	412,074	13,646	87	3.3
1900 .....	15,171	432,692	14,356	94	3.3
1901 .....	17,209	484,172	19,839	115	4.1

The increase during 1898 was 27.9 per cent, during 1889 the increase was 15.2 per cent, and in 1900 it was 5.4 per cent, although the real increase during this latter year is undoubtedly greater than the number obtained from the inspection record. The average rate of increase is much greater than that of the population or of the total number of children between the ages of 14 and 16 years. The increase might be accounted for largely by the increased amount of general employment.

In showing the natural tendency of child-labor to increase, it is important to look outside of our own state, because industrial tendencies are usually spread over a wide territory and, while one state may form a temporary exception, in the long run it is sure to follow the general rule for the country or section in which it is located.

The factory reports of other states show the same tendency of child-labor to increase, except

when a new law or a more rigid enforcement of the old ones have taken the children out of the factories or shops or put them into the schools. On account of the fluctuations in trade, adults are sometimes more rapidly absorbed into the industries than children, so that the percentage of children, to the adults may during such periods be lowered; but it is usually found that the number of children employed has increased more than the total number of children of the same age in the community.

Seventy-five per cent of the children employed in the factories and mercantile establishments of Illinois are at work in Chicago. The nature of the employment in which the greater number of children are occupied in this city is shown from the record of inspection by this department:

principle that public policy demands the regulation of the employment of the physically, mentally and morally immature who are, therefore, at the same time economically, legally and in a political sense, dependent. The amendment and extension of our child-labor laws demand no new principle of legislation in Illinois, have for their precedent laws of the leading manufacturing states, are in harmony with the policy of the common law and with the Constitution of the United States and of Illinois as interpreted by the Supreme Court of this State. But as the whole subject has not been treated at any length in this report for several years, it will be of value briefly to review it here before going on to point out the defects and insufficiency of our present laws and the remedies suggested by the experience of this department.

### CONDENSED STATISTICAL TABLE OF THE DIFFERENT INDUSTRIES.

INDUSTRIES.	Number of places inspected	Total number of girls under 16 years.	Total number of boys under 16 years.	Total number of females over 16 years.	Total number of males over 16 years.	Total number of children ten under 16 years.	Total number of employees	Per cent. of children to total employees.	Number of children to 1,000 employees.	Number of employees to 1 child.
Breweries and soft drinks.....	105	12	87	98	4,024	99	4,221	2.3	23	43
Brick, stone and terra cotta.....	81	72	15	3,141	72	3,228	2.2	22	45	
Cigars, cigarettes, tobacco.....	370	161	63	1,114	2,279	224	3,617	6.2	62	16
Department stores and other large stores and offices.....	304	1,513	1,552	20,394	33,710	3,065	57,169	5.4	54	19
Dusters, brooms, brushes.....	28	19	11	106	287	30	423	7.1	71	14
FOOD—										
Bakeries.....	337	272	73	1,162	2,584	345	4,091	8.4	84	12
Confections.....	97	375	24	1,545	1,619	399	3,563	11.2	112	9
Restaurants.....	30	5	.....	319	1,949	5	1,273	0.4	24	255
Other foods.....	182	260	537	2,948	23,477	797	27,222	9.9	99	34
Garment makers.....	5,313	2,416	569	25,673	21,759	2,985	50,417	5.9	59	17
Glass.....	36	53	45	909	53	1,007	5.2	52	19	
House furnishing, upholstery.....	152	93	111	721	1,396	201	2,291	8.9	89	11
Jewelry.....	116	3	63	316	1,568	66	1,980	3.3	33	30
Laundries.....	225	244	24	3,606	1,356	268	5,227	5.1	51	19
Leather industries.....	223	185	285	1,574	6,955	470	8,999	5.2	52	19
Metal Working trades.....	1,095	177	1,522	4,261	84,161	1,699	90,121	1.9	19	53
Musical instruments.....	43	11	288	82	4,019	299	4,000	6.9	69	15
Paints, oils, glue, varnish, painting.....	106	14	45	393	3,222	59	3,674	1.6	16	62
Paper, paper boxes and bags.....	97	420	223	1,677	2,767	643	5,087	12.6	126	8
Pharmacies, proprietary medicines, surgical instruments.....	119	46	57	862	1,992	103	2,957	3.5	35	29
Portraits, artists' specialties.....	122	9	38	445	953	47	1,405	3.3	33	30
Printing and publishing.....	582	161	429	3,134	11,970	590	15,694	3.8	38	27
Rubber goods.....	26	.....	40	42	464	40	546	7.3	73	14
Signs, advertising novelties.....	62	1	10	19	396	11	426	2.6	26	39
Soaps, perfumes, toilet articles.....	34	35	56	115	571	91	1,477	6.2	62	16
Sponging, dyeing, cleaning.....	146	3	11	295	545	14	834	1.6	16	61
Stationery, school supplies.....	37	24	41	318	577	65	960	6.8	68	15
Stores and offices.....	2,131	52	328	2,975	12,800	380	16,155	2.4	24	42
Telephone, telegraph and express offices.....	75	.....	479	519	2,201	479	3,199	14.9	149	7
Tents, awnings, cordage, bags, flags.....	34	57	34	627	728	91	1,446	6.3	63	16
Unclassified.....	93	35	55	584	1,869	90	2,543	3.5	35	28
Vehicles.....	107	.....	25	19	1,876	25	1,920	1.3	13	77
Wood working.....	517	125	1,648	883	23,317	1,773	25,973	6.9	79	15
Totals in Cook county.....	13,027	6,728	8,853	77,493	260,491	15,581	353,565	4.4	44	22
Towns outside of Cook county.....	4,182	934	3,304	17,036	109,313	4,258	130,607	3.3	33	31
Metal polishing wheels.....	10	.....	.....	.....	.....	.....	.....	.....	.....	.....
Totals.....	17,210	7,662	12,157	94,529	369,804	19,839	484,172	4.1	41	24

The child-labor laws aim at two things: A prohibition of employment in certain occupations of children under 14 years of age, and the protection of children above that age. In the first aim, the law has been only partially successful; in the second it has been a complete failure. Both objects are based on the

#### Causes of Child-Labor.

That we have in our State and country such an army of child-workers would suggest to many the experience of some underlying cause representing such industrial and individual necessities that it would be perilous to restrict it in any marked degree by legislation. And



it must be acknowledged that both our industrial organizations, and our economic institutions forbid easy generalizations or hasty remedial legislation—whatever may be the evils resulting from children's work. There are several considerations, however, which seem to show that child-labor in its present form is neither economically necessary nor suited to American social traditions and political institutions.

It is not customary for American-born workmen to put their children into the factories at an early age. They are believers in our educational system and realize the inconsistency of educational ideal with factory labor for immature children. Only in cases of great want do they allow their children to work until they have at least completed their common school education, and then it is usually to seek employment for them in a store, to teach them a trade or to find work for them at an occupation where something is to be learned and advancement is possible. With the immigrants, among whom the vast bulk of our child-labor is to be found, the case is entirely different. In their European lives, child-labor was both a custom and a necessity, which they are slow to change even when meeting with improved conditions in this country. Among certain races, it is almost an invariable rule, whatever the conditions of the parents.

Another cause, which seems inconsistent with the general welfare, is due to a natural demand on the part of the employers for additional help in those trades in which there are great seasonal or trade fluctuations. "Experience seems to confirm that increased business activity, or demand for labor, often causes the employment of an unduly large proportion of children. An explanation of this can probably be found in the fact that in many manufacturing places additional help can be more easily obtained from the ranks of children than from adult workers. In times of business expansion therefore it is only natural that children should be employed whenever they can be used to advantage, and particularly if adult-labor is scarce."

From the standpoint of society, as a whole, we will say that a uniform law for all manufacturing states, under which no child under 15 years could be employed and which compelled school attendance up to this age, would be preferable to the present laws. If we are ever to reach the industrial supremacy predicted for us, it can only be because of a superior industrial class. Such a class can nowhere be had without the most careful bringing up. Many employers overlook this. Circumstances are also often such that they are forced to disregard ultimate for immediate results. The state, however, cannot afford to be unmindful of future requirements of the growing race no matter what individuals may think.

In the light of the purpose and function of our public school system, its immediate successor in the child-life must likewise be of extreme public importance. There is no feature of American civilization that we value

more than our public schools. They are the justification for universal suffrage and political liberty, the safe-guard of a nation and the foundation of its prosperity. All the complex and manifold reasons that lead us to uphold and develop the system would likewise demand that its benefits should not be cut short and negatived by premature and injurious labor. These reasons cannot even be suggested here, but it is evident that commerce, industry, legislation and administration would go back to barbarism if the care of the young were neglected for a single generation. The prevalence of child-labor goes hand in hand with illiteracy, insufficient schooling and all their degrading consequences.

Firms in Chicago and Cook county employing more than 50 children:

The Fair, State and Adams sts.....	500
Heywood Bros. & Wakefield Co., 464 S. Washtenaw ave.....	292
A. M. Rothschild, VanBuren and State sts..	237
Marshall Field & Co., State and Washington sts .....	227
Siegel & Cooper, State and VanBuren sts...	202
Western Union Tel., 122 LaSalle st.....	200
F. W. Rueckheim & Bro., 261 S. Desplaines st .....	181
Cable Piano Co., 999 S. Paulina st.....	175
Postal Tel. and Cable Co., 148 Washington st .....	162
Armour & Co., Union Stock Yards.....	160
W. C. Ritchie & Co., paper box mfg., Van Buren and Green sts.....	150
Schlesinger & Mayer, State and Madison st.	150
McCormick Harvesting Machine Co., Blue Island and Western aves.....	115
National Box Co., 38th and Center ave....	101
Mandel Bros., State and Madison sts.....	100
Great Northern Moulding Co., 705 Sangamon st .....	100
Hillman's, State and Madison sts.....	91
Nelson Morris, Union Stock Yards.....	88
Swift & Co., Union Stock Yards.....	86
Spaulding, Merrick & Co., 9 Rush st.....	77
Libby, McNeil & Libby, Union Stock Yards.	74
Chicago Picture Frame Works, 77 Weed st.	72
Carson, Pirie, Scott & Co., State and Washington sts .....	68
Brink's Chicago Express, 132 W. Monroe st.	66

Firms outside of Chicago and Cook county employing more than 50 children:

Illinois Glass Co., Alton, Ill.....	377
Streator Glass Bottle Works, Streator, Ill..	257
National Enameling and Stamping Co., Granite City, Ill.....	122
Western Tube Co., Kewanee, Ill.....	114
Aurora Cotton Mills, Aurora, Ill.....	70
Stationer's Mfg. Co., Quincy, Ill.....	68
Nelson Morris & Co., East Louis, Ill.....	67
Nelson Knitting Co., Rockford, Ill.....	66
Rockford Mitten and Hosiery Co., Rockford, Ill.....	62
Swift & Co., packers, East St. Louis, Ill...	61
Grife Bros., mfg. of keys, Joliet, Ill.....	57
National Cooperage and Woodenware Co., Peoria, Ill .....	51
Illinois Aluminum Co., Lemont, Ill.....	51
American Steel and Wire Co., Joliet, Ill....	50

## PHYSICAL EFFECT OF CHILD LABOR UPON THE INDIVIDUAL.

By John C. Cook, M. D.

Says Spencer, "Overpressure has long divided and passionately excited men of intellect." Let us think for one minute what is expected of a child by the time it reaches puberty and we will see how illy prepared for manual labor or to become a wage earner this soft specimen of humanity is. A baby weighing seven pounds at birth is supposed to double its weight in five months, to triple it before it is fifteen months, to quadruple it by the time it is four years old and again by the time it is thirteen. What sort of body is this to do from eight to twelve hours mental labor in twenty-four hours, actually working from one-third to one-half of the entire time? This is the average well-kept, well-fed and domiciled child, weighing at ten years fifty pounds, measuring about four and three-quarter feet, increasing by the time it is fourteen to eighty pounds, and measuring nearly five feet. What has occurred during this period from ten to fourteen? A whole human organism has been developed with many periods of stress, fatigue and shocks. We have grown two sets of teeth and developed a complete secretory and excretory glandular system, undergone the various changes from infancy to childhood, childhood to puberty, and puberty to adolescence, with all its anatomical, physical and functional changes. Besides this, an education is to be acquired,—the checks learned. More knowledge is to be stored up than at any or all other periods of equal or double duration, and how easy it is to over-tax them or let them over-tax themselves, for in childhood or youth the demands upon the vital energies are various and urgent. Now, add to this manual labor of long hours, over-application and over-taxation, and we will see the fatigue lines increase in length and number, for the waste consequent on the day's bodily exercise has to be met. During this, fits of rapid growth sometimes occurring in childhood, a great obstruction of energy is shown in an attendant prostration, bodily and mentally. Additional growth of body has to be provided for if we would keep symmetry requisite to a harmonious balance.

Excess of bodily exercise diminishes the power of thought, and if this be true, can it not be readily seen that the long hours not only diminish the power of thought, but the power to think. Excessive use of the muscular system during the period of childhood, puberty and adolescence not only interferes with, but permanently arrests, the development of the central and peripheral nervous systems, inducing early somnolency. As the tired muscle curves on itself, so does the tired brain. Instead of having a child of ten weighing fifty pounds, we get one weighing from thirty to thirty-five, all skin and bones, three and a half instead of four and three-quarters, as we should have, in height, with all the youth gone—wizened old man or woman doomed to decay before it knew how to play—characterized by

extreme pallor, an age-worn expression infinitely pitiful and incongruous in a child's face, never having known the joys of childhood or felt the bubbling fount of youth tingle through its veins, never having been accorded the privilege of a pig to eat and sleep in peace, but urged on to tasks that it is illy able to perform, shy and morose as a hunted down wild animal. If you catch its eye at all it is only for a glance. It slinks away or crouches in a corner, instinctively recognizing its own poverty and inferiority to its fellow creatures. As you look at one of these overworked children, you can not help feeling a shudder to think they are of your own flesh and blood and children of our free America that we want to call God's country. Fortunately, most of them fill short graves, falling a prey to some acute intercurrent disease or succumbing to some of the afflictions that follow in the wake of over-taxed and under-fed and clothed humanity. The few that live grow into ill formed degenerate looking specimens. If they reproduce themselves, as some of them do, it requires no stretch of the imagination to contemplate their off-spring. Even Kiernan or Talbott would find difficulty in placing them in their class; and for what are they selling their blood? I am told as low as nine cents a day is paid and that fifty cents a day is considered good wages, and the "pound of flesh is strenuously insisted upon," and that wages are diminishing instead of increasing, showing that the supply exceeds the demand. Children as young as five years are found at work. Fortunately, some figures give us encouragement. A recent government report shows that in New England the number of children working has fallen from 18,000 to 11,000; in the middle states from 6,000 to 4,300; in the west from 500 to 300; but in the south it has risen from 4,000 to 25,000. England, France, Russia, Germany and Austria have all been through this fight and have all solved the problem by removing the children of tender years from the factory and sweatshop, and it appears to me that a sentiment against this form of slavery should emanate from a representative body of medical men whose chief aim in life is the betterment of humanity. We, as a nation, have recently poured out good blood to do away with a form of slavery not as far-reaching in its derogatory influence on the human race or as humiliating to our national pride as child labor as it is carried on in our sweatshops of the North and the cotton mills of the South. The acute diseases that most commonly attack and carry off these frail and ill nourished bodies are bronchitis, pneumonia, bronchial in the North and croupous in the South, pleurisy with its adhesions and effusions, inflammatory rheumatism, purpura hemorrhagica and the various forms of anemia, bringing in their train the dilated heart with all its consequences. One of the most common complaints among the cotton mill workers of the South is a form of idiopathic edema, and catarrhal conjunctivitis from which many of them lose their sight, is a prevalent difficulty. Among the chronic pathological changes that occur from this over-taxation of the physical economy, first in order of prominence is prob-

ably tuberculosis in all of its varied forms from pulmonary to miliary, attacking all the tissues especially the bones and the intestines. Hip joint disease and spinal curvature is too common among this class. Next in order probably is sub-acute or chronic rheumatism with all its complications and sequelae, not least among which is the heart lesions so common among this class that doctors seldom dismiss a case without looking for it and too often find it—soon to be followed by dropsy and death. The most common form of nervous disease found in this class is chorea, St. Vitus's dance, in all degrees from the little, shrinking, trembling girl to the big choreic boy whose nervous system has been so shocked that he cannot stay in bed without being tied. Add to this the many maimed by accident. They are too worn out, too dull of perception to protect their little frail bodies, self-preservation and the love of life gone.

#### CHILD LABOR FROM A MENTAL STAND-POINT.

By W. L. Bodine, Superintendent of Compulsory Education, Chicago.

"Child labor is the real American peril. It is the toy of the trusts, the foe of the schools, and a constant menace to the intellectual development of a great nation. The children in the factories today are the fathers and the mothers of the future. What will that generation be mentally—what will it be physically—and what will it be morally, if the evil is not crushed? We have stricken the shackles of slavery from the wrists of the black men of the South, but the serpent of child slavery crawls through our factories, our workshops and our stores, destroying the child's paradise and leaving many victims of blighted education in its trail. In the cotton mills of Georgia, in the workshops of our great cities, in the factory-dotted valleys of New England, and even down in the black bosom of Pennsylvania's coal mines, the cry of the children is being drowned, day by day, by the unsympathetic song of the wheels and the din of industry.

"Child labor, as viewed through the gold-rimmed glasses of commercialism, is a picture of economy, pleasing to the eyes of Mammon and a source of infinite contentment to the soul of Poverty. In it, the employer sees investment in human machinery, a bargain in little hands and arms, and sad-eyed children's faces, paled by the withering life in the workshop. To these employers, there is nothing so cheap as children. These children know no school, no play, no education. Their lives from sunrise to sunrise is bounded by an humble home and a noisy, smoke-fogged factory. With the flag of this great patriotic nation waving from the top of free schools, in free America, round about them, these children can only look out of a dingy factory window at these reminders, and sigh over their future in life—a future when they will have attained manhood and woman-

hood only to find themselves mentally incapacitated and physically unfit for further usefulness in life. It is then that they will realize how priceless is the value of an education, and how dearly they have paid for opportunities lost—and—forever, beyond recall.

Chicago—our own beloved, imperial city of the West, can point to the glory of its growth, to great rows of smoke stacks and towering facades of manufacturing plants, but there is one thing to which Chicago, silent and shame-faced, hesitates to point the finger of pride—and that is the sign over the factory door: 'Abandon Education all ye who enter here.' It's danger is written in the hearts of children, but it is not sufficiently written in the minds of men, to the disgrace of civilization and the detriment of a public school system that is the hope of the republic.

"Our schools have been quietly, but systematically, robbed year after year, by the factories. Great institutions have been built upon the bones of little white slaves, who have been taken mostly from the sixth, seventh and eighth grades in our schools, and put to work on false affidavits filed by parents. The child is delivered in bondage, at the price of its mental, physical and frequently, its moral future. There are several thousand children under fourteen years of age, working in the factories of Cook county today, who have been smuggled to work through a loophole in the present child labor law—a condition of affairs, for which the state factory inspector, and other officials, responsible for the enforcement of laws, cannot consistently be criticised. From a mental standpoint, these children will battle with the world, the remainder of their lives, with a sixth grade education, and some of them will soon forget that. The result will be a premium for illiteracy, and a family in the future, uneducated and un-American. Children between the ages of twelve and fourteen years are just at that period in school life when their mental aptitude is keenest and at its best in the grammar schools. But where are the boys today at the graduating exercises of the grammar schools? You see many girls, but the boys—where are they? I will tell you where they are. They are at work at measly salaries ranging from \$1.50 to \$3 per week, and I know of one instance where a boy sacrificed his education at the age of fourteen for 25 cents per week and board. Boys, today, develop a taste for commercialism. It is in the air. They have absorbed it as men have absorbed it. The nation is wealth-mad. The people want money. Some work for it, some kill for it, some die for it. Many fathers reckon, when their sons and daughters reach the age of twelve, thirteen or fourteen—'what is that child's earning capacity?' To them the productive value of a child is more than education. And some employers are lax in their conscience in cases of doubt of a child's age, so long as the affidavit is presented.

"In the official census returns of 1900, the percentage of children in the United States,



between the ages of 10 and 14 years, who could read and write, the following states led:

- 1st. Nebraska, 99.66 per cent.
- 2d. Iowa, 99.63 per cent.
- 3d. Oregon, 99.58 per cent.
- 4th. Kansas, 99.48 per cent.
- 5th. Connecticut, 99.43 per cent.
- 9th. Massachusetts, 99.33 per cent.
- 14th. New York, 99.26 (an increase from 98.62 in 1890.)
- 15th. Illinois, 99.18 (an increase from 98.75 in 1890.)

"In Georgia, where child labor goes unrestrained, and where there is no compulsory education law, the state ranks near the bottom, with a percentage of 77.21.

"It will be observed by this table, that in the agricultural states, where there are no large cities and where there are comparatively few factories, the percentage out-ranks Massachusetts, New York, Illinois and other manufacturing states where there are metropolitan centres.

"It has been the theory of poets and philosophers that 'God made the country and man made the town,' and I might add, incidentally, that the man who makes the town, as a rule, comes from the country. In Chicago and other large cities our successful business men were country born, and bred—men whose boyhood was not blighted in factories—men who have not been stunted physically and mentally by child labor. True, they have worked in earlier years, but they worked amid green fields, in sunshine and fresh air; and they tempered their industry with attendance at the little red school house. Their education was one of heart interest to them. They were beyond the alluring clutches of the factory. Moreover, they sought the light of mental advancement, with an ambition in life. Their parents were American in their ideas. They realized the value of education. In large cities, poverty, greed and cosmopolitan population exists the most. It is here that the spirit of money-getting menaces education, more than it does in smaller communities. It is to the large cities that the foreigner comes with a brood of children, for the poor, as a rule, are good at multiplication. He finds his expenses heavy and reckons on the earning capacity of his children more than their intellectual uplift beyond the elementary grade. It is in the cities that the factory tempts the sacrifice. It is here that the gambling mania fills not only the mind of man, but the mind of the child. Parents gamble away their wages, in some instances, and not infrequently, the child's earnings go into policy shops. Children frequently are eager to leave school and go to work, so as to earn money, to get a touch of commercialism. There is, for the child, a fascination in the jingle of a few paltry dollars when the pay envelope comes to them once a week. It is the voice of silver luring other children from school. But let us figure the inevitable price of the sacrifice of education. All children, according to the affidavits on file at the factories, etc., are fourteen years of age, but they are not. Hence, I calculate that a child between eleven and four-

teen years of age earns on an average of from \$2 to \$3 per week, or about \$135 per year, if the employment is regular. If a child is smuggled into a factory at the age of 11, he will have earned, at the age of 16, with allowance for lay-offs and for a slight advance in wage schedule, \$740 in five years. In the meantime, for that pittance, the child's mental faculties have been bankrupted, its education has been sacrificed, and its physical growth is stunted, so that when manhood is attained, the victim of child labor finds himself incapacitated in mind and in muscle, with the result that his earning capacity in the remaining years of his life ebbs until it reaches the minimum. The sequel is, that the parent has a burden on his hands, or else the county must make provision for another dependent's berth at the poor house—or perchance, an unmarked grave in the potter's field. The taxpayer pays the freight on this child labor traffic in the end. In the battle with the world, Mind out-ranks Muscle in the wage schedule. Lack of mental equipment in a boy means lack of earning capacity in the man. Lack of mentality in a girl means lack of fitness to raise children when she becomes a woman.

"Child labor strikes a boy or girl down in the prime of mental aptitude at school. This is a pathetic truth. It seems pitiful that the factory yawns for children at the time when their minds are ripest for their studies. In the percentage of promotions from grade to grade, in our public schools, the children under ten and eleven years of age, from the first to the fourth grades, rank 79.7 per cent in advancement each year. In the sixth, seventh and eighth grades—covering children from eleven to fourteen years of age, the percentage of promotions averages 82.1 per cent.

"In numerical strength, 64 per cent of the total enrollment applies to the first five grades, while 35 per cent of the enrollment applies to the sixth, seventh and eighth grades.

"The high school grades are the ninth, tenth, eleventh and twelfth. Only five per cent of the children enrolled at our schools, in first grade in 1889, remained to finish the last high school grades in 1900. And only 30 per cent of this comparative enrollment finished the eighth grade. As soon as they were fourteen years of age, having complied with the compulsory education law, many of them left their books to go to work in some factory, office or store.

"Many white parents in Chicago could well afford to ponder over the fact that the negro father, equally poor, manages to send his child to school and keep him out of the factory. In a recent tour of the east, when I visited every truant school, I saw only four little black faces in all these corrective institutions; you see very few of them in our factories, and comparatively few are truants. Is there not a pathetic eloquence in the fact that the black man, realizing how his race was deprived of an education, before slavery died on the ashes of a conquered confederacy, is determined that his children shall have their minds stored with the knowledge denied their fathers.

The reason that the schools suffer from

child labor is due to the fact that under the present child labor law a parent can put his child to work by merely affirming, under oath, before a notary public, that the child is fourteen years of age. This testimony is not verified by the school age record. The affidavit has precedence, Parental perjury, although apparent, is difficult to prove, especially when the mother who gave the child birth, uplifts the hand that rocked the cradle, and swears to the day and the year when that child was born. The law should be amended so as to compel a verification of the child's legal age of fourteen, by filing with the affidavit, a certificate or baptismal records, by a certificate from the principal of the school the child last attended, showing that the school records corroborate the parent's affidavit.

"The present compulsory education law also needs amendment, to compel school attendance for the full school year, instead of sixteen weeks, because some parents are tempted to put their children to work in the interim, between the sixteen weeks compulsory attendance and forty weeks, which comprises the full term. There is a gap between the new laws that must be bridged in order to attain more successful results. Under the present laws, by reason of the vigilance of factory inspectors and truant officers, and by the prosecution of parents, in some instances where it was possible to secure church records, child labor in Chicago has been held in check—more so than in previous years. But we need more factory inspectors and more truant officers to protect the interests of children under fourteen. Illinois has only 12 factory inspectors—a heroic dozen, with a live chief at their head. Chicago, the only city in the state where the compulsory education law is enforced, has only twenty truant officers to cover 300 schools.

"In the public night schools, in the meantime, lies the hope of mental salvation for many children and parents in Chicago. The night schools in the city this year, rank higher than ever in the superior attainments of its teaching corps, thanks to Superintendent E. G. Cooley and the board of education. With night schools in the winter and vacation schools in the summer, with stronger laws governing child labor and compulsory education, and with adequate facilities to enforce them more rigidly, Chicago will reduce illiteracy to the minimum. The present officials do the best that can be done under present laws and with present facilities. I can see the awakening of public interest in the subject—thanks to such sympathetic assemblages as are within sound of my voice tonight.

"But who was the first to respond to the alarm over child labor, I sounded in my annual reports, made by the factory inspector and myself, two years ago. Was it the business man? No, he was too busy figuring on the profit and loss, and following David Harum's golden rule: "Do unto others as they would do unto you—only do them first." Was it the lawyer? No, he was in the throes of brain fag over complex litigation. Was it the manufacturer? Hardly. He was deaf to anything that

interfered with economy in the operation of his plan. I will tell you who first responded to the cry. It was that great sisterhood of love for home and school—The Women's Clubs of Illinois—that took up the battle for the intellectual protection of our children, and today, from Cairo to the Wisconsin line, every mother and every sister, whose voice can control a vote in the next legislature is pleading for a new child labor law, to better protect our children from the blighting grasp of the factory. And you—the Physicians' Club of Chicago, by reason of your valuable co-operation, have proved that you are also physicians of the soul. To the members of the legislature, honored with the votes and confidence of the people, I say: 'Give us a more effective child labor law—men of Illinois—and I pledge you that I will back up the state factory inspector with every truant officer at my command, barriers will be swept away, and we will rescue every child under fourteen, from the perils of factory life and place them in school, where they belong. There, they can grow up into intellectual and useful citizens of a country for whose freedom men fought and women prayed, in order that children might be raised in the faith of liberty and education, by means of a great American school system that shall never perish from the earth."

The next speaker on the program, Mr. M. M. Mangasarian, addressed the club on **The Moral Effects**, without notes. He said he was glad to see the physicians taking up this question of child labor. Certainly it fell somewhat within the province of the medical profession, as it affected the health of the community and that of future generations. There was too much of a tendency nowadays to specialize and limit one's work and thoughts. This is true of the professions as well as of the commercial callings. In one who is a tender upon the sick, this especially is a great loss. Hence he believed in the sentiment that we all ought to be broad-minded men, interested in everything pertaining to human progress and activity. Especially ought the physician be such a man.

He then referred to the statement of one of the preceding speakers, namely, that of all the affidavits taken up in regard to the ages of the children employed in factories and stores, 80 per cent were found to be false. He asked if this was not the center, the gist of the whole question. Eighty per cent of sworn affidavits found to be false! Most of these affidavits of course were made by ignorant and irresponsible immigrants and here another element in the question is opened up. This whole question of immigration is a large one, but upon it hinges many important side questions for us. One of these side questions is the one we are discussing tonight, namely that of child labor.

Here the speaker dwelt upon the evils of too free and too promiscuous immigration. He declared that foreigners, as a rule, are not interested in this country, and when they come here they are granted too much freedom, which in their ignorance they confound with license.



He believed no person should be allowed to vote until after an attendance of 14 years in school or other educational institutions. Fathers and mothers, as well as their children, should be told that unless they are educated they will not be allowed to vote. This, he believed, would be one important remedy for the monstrous evil of child labor. In Europe it was a fact that the number of educated people was slowly but surely diminishing, whereas that of the illiterate was steadily increasing. In Rome and other great centers of population this is all but too obvious. Look at Spain and compare what she is today with what she was a short time ago. The best and brightest people went into the church where celibacy was enjoined. As a result it was left to those outside of the church, the illiterate, comparatively speaking, to propagate the race. This process going on in this way during so many generations in the past, Spain was gradually forced lower and lower until today she is in the fourth instead of the first class of the great nations. This same thing will occur to America, if we do not take care to curb the illiterate and foster the educated. In the twentieth century America will sink as Spain has sunk. Illiteracy being the prime cause of this national decline, the stealing of children from the schools in order to work them in the factories of our land is a means of hastening the decline of our national honor and strength. Those who do it are to be held accountable for the future of our country.

One of the previous speakers had said that in Cook county 100,000 children were shut out of school, for all or part of the time, on account of lack of room. And yet in this country we pride ourselves upon our school system and upon the fact that education is given free to all the people. It is clear that something is wrong and that we need to be improved in this direction too. With our great industrial progress we have developed the tendency of striving after wealth as the greatest thing in life. This coarse materialism is dangerously rife in our land. Great wealth is not the most desirable thing and what we need more of is idealism, an idealism that sees beauty in art, literature and speculative science. With mere material greatness we become merely a nation of buyers. The wealthy man of small education may have his palatial residence and may be able to purchase magnificent editions of Shakespeare, but after he has carted them home and set them up in his library, he is unable to enjoy or even to appreciate them. He has missed in life the very thing that makes life worth living. He has struggled all along for the material of life, his wealth and has completely overlooked its ideal side as found in the beauties of nature and nature's interpreter art. It is better to be the nation that produces a Shakespeare than a nation that is merely able to buy him. We must cultivate the poetry of life, the ideal and the noble; else we will become a cheap nation, a community of cheap men with merely a few extra dollars in our hands wherewith to buy the brain products of other nations. Immigrants come here to make money. They are too illiterate, most

of them, to care for the better and higher things in life. Hence, if we want to preserve our great and glorious land from following in the wake of Spain, we must curtail immigration, suppress illiteracy, foster education and develop idealism. One way to do this is to put a stop to child labor as it is permitted today in some places.

Mr. Harry S. Mearney stated that he felt a special interest in this subject of child labor as everyone did who was interested at all in the lives of the little folks and the future welfare of our nation. A nation is but a collection of families and a family is but a collection of individuals, not the least important of whom are the children. Hence everyone must recognize the extreme importance to the welfare of the nation of this subject of child labor. After all the gist of the question narrows itself down to the question of competition. Competition is the mother of progress. It exists among individuals, children as well as adults. It cannot be legitimately suppressed. Nor is it desirable to suppress it. It is competition that leads insidiously into the employment of children. Hence child labor cannot be suppressed; it can only be regulated and safeguarded. The speaker said he for one believed in child labor and that one of the great troubles of America was that too many American children were without labor. That is, they were allowed to have too many idle and purposeless hours on their hands. After school hours and before, they were permitted to roam and do as they wanted to, often getting into dangerous mischief, whereas a certain amount of physical labor to offset their mental work in school would both rest and do them good. Idleness was not rest as recreation and the reason that so many of our greatest men have developed out of the poor country lad is that they were early trained to do systematic and definite work with their hands. There are hordes of idle fellows all about us who do nothing but go to school. They are on the streets and too often drift into the saloon and other dangerous places. Such fellows need a little systematic hand work. Labor with the hands is the first and best kind of labor. We as a nation have gone education mad or rather school and college mad. Too much education is as dangerous as too little. We are tending to become overburdened with books and booklore. Millionaires are flooding the country with libraries. Not enough dignity is attached to the work of the farmer and the mechanic and all that class of people who do and make things with their hands. Hence child labor in itself is a good and proper mode of development, both of the individual and of the community. It is but one form of competition. The sole question in regard to it revolves about its control and reputation. Its suppression would be a calamity; its regulation is a necessity. Manual labor is the real basis of all education. Book-learning is after all but a rehearsal of what men do and make with their hands. Hence child labor is one form—perhaps the most important form—of education. It develops those qualities that make the man and



right citizen and strong nation. It cultivates habits of industry and concentration and purpose. Such habits in every walk of life lead to success. Successful men both in the professions and in commercial pursuits, have all worked more or less with their hands. If such work were more cultivated, there would be no need of football and athletics and gymnastics in our great universities and the sum total of the results obtained would be immensely more valuable.

The abuses of child labor that we have heard of here tonight are of course all bad and must be stopped. The factory and the store is no place for the child. Their evil influences spring out of other factors than the mere labor expected of the child there. There are no parents there to guard and protect the child from these influences. The same labor at home under the guidance of a devoted father or mother would not prove deleterious as it does away from their guidance in the industrial marts. There is no congenial companionship in the factory and store; no encouragement or correction such as only a father can give. Compare the farmer lad with the boy of the same age in the city factory. The former probably does more actual and harder labor than the latter, but there the father and home influences are absent, while here these influences affect the lad in his work to his good. The factory environment is too severe for childhood, too narrow, too much of a routine. Four and six hours of steady work in one narrow routine is too exhausting for a growing child. It makes one's blood boil with righteous indignation to hear of the evils of the system in vogue in some of our factories. The owners of such places should be held up to contempt. Their doings are simply despicable. We must fight the factories and get the children out of them and back to their homes. This is said to be a hard task. The homes are not gardens of paradise. Then we must turn our attention to the homes. It is not a good argument for child labor in factories to say that the homes are cheerless and poor and uninviting. One evil does not mitigate another. The home is the place for the child where he can be educated and learn to labor under the guidance of his parents and guardians. If the home is at fault, we should devote our energies then to its correction.

The speaker further said he did not believe in laws very much for the mitigation of such universal evils. Laws are too numerous now; laws can only abate abuses; laws cannot set right customs and correct ideas. Only the education of the community in right lines can do that; only the cultivation of a higher and better sentiment among the masses. As in school matters and book-learning, we as a nation have become almost law crazy. We attempt to do and regulate everything by law. This is folly. Personal efforts and more of it, is what is needed. We should each individually go to the parents and urge and persuade them to release their child from this modern form of bondage. In this direction there is an enormous amount of work for a whole lot of

people to do. Personal work, if largely exerted, can do infinitely more than all the laws upon the statute books. The medical profession, by coming so intimately into relations with the people, especially can do a magnificent educational work along these lines. There is too much legislation, too much writing, too much talking about this subject. What we need is more hard personal effort. There is as much patriotism in this kind of work as there is in shouldering a musket and going to war. Our country today calls for patriots of this sort and if they will unite as they do in times of war and shoulder to shoulder, face this enemy of child labor, it will go down and the future of our country will be assured.

After the regular program the discussion was opened by Mrs. Harriet Van Der Vaart, chairman of the Industrial Committee of the Illinois Federation of Women's Clubs. She agreed with the last speaker in regard to the supreme value of personal work. The people should be educated as to the danger and monstrous wrongs of the abuses of child labor. She referred to the false affidavits and said that they showed to what extent ignorance and indifference would go in the effort to get work out of children. Poverty and dire necessity sometimes led to this and sometimes it was due to human brutality. Among the worst offenders among employers of child labor, she believed, the box factories ranked first. She had visited many of them and from what she observed there she was led to condemn the system of paying by what is called piece-work, especially when there is not a fixed limit put upon the time and amount of work to be done by each child.

She had visited a factory where they paid seven cents per thousand. It is obvious that this acts as a powerful stimulant to the child to do an excessive amount of work. In the manipulating of a certain rapid machine a little girl was compelled to make about 15,000 rapid, monotonous flexions of her body in one day. Not only the attitude and physical labor necessitated by this but the frightful monotony of the work, must necessarily tell deleteriously upon the physical and mental development of the child. Some children never see daylight for they work ten hours a day in dark rooms, under artificial light and have to allow an hour at both ends of the day to go from and return to their homes. The invention of machinery and the high degree of specialization in the modern factories, increase to a dangerous extent the monotony of the work. This is one of the growing dangers of the modern method and tells severely upon the development of the young who are employed under it. In former times the occupations were more varied and consequently less injurious. The speaker then spoke of legislation and said that while it was not a cure-all and could not entirely replace the personal work referred to by the last speaker, it nevertheless had a restraining influence upon abuses and was therefore desirable and necessary. The Federation of Women's clubs was taking up this matter and were about to ask for special legislation upon

the matter. (In the hands of each of the members of the club was placed a pamphlet entitled "Child Labor in Illinois: A Plea for Better Laws," and issued by the Industrial Committee of the Federation of Women's Clubs. Also another pamphlet containing some interesting and instructive statistics showing the illiteracy and increase of child labor in Illinois as well as the main points of the proposed child labor bill.) As the speaker said, the main points of the proposed legislation were three-fold, namely:

1. To require an educational test before beginning work.

2. To make the affidavit effective, thus preventing the employment of children under fourteen years of age.

3. To stop night work of children.

Frank S. Churchill, the next speaker, dwelt upon the fact that an age limit was not so good as physical measurement, weight, development, etc. He thought that it would be too arbitrary to say what children should and should not be allowed to work merely upon the basis of their ages. They differed greatly in regard to capacity for work at the same ages. The test should therefore be the child's physical condition. He said he personally had much sympathy for the poor mothers and was not surprised, when he saw how dire their necessities were sometimes, that they should relax their conscience a bit and swear to false affidavits. The temptations at times would seem to be quite irresistible. The temptation will continue to exist so long as such an arbitrary standard as age-limit is adopted. If the child's weight, height, physical development, etc., are taken in conjunction with his age, the decision of the matter will be taken entirely out of the hands of the interested mothers, a better class of tests will be employed and false affidavits will not appear. These tests will not be so difficult to carry out as at first sight they appear to be. There are compiled tables of standard and normal conditions and these employed as guides in the hands of a corps of physicians could easily be made to show who among children were or were not able to do manual labor called for in the factories and elsewhere. These physicians could be appointed under civil service rules and paid by the state.

W. S. Christopher next showed how difficult it is to determine a child's age from its physical constitution. Hence we must largely depend upon the sworn statements of the parent's in this respect. Moreover it proves the fact that age is not a good criterion to go by, as the physical constitution of children differ so markedly even at the same age. Dr. Christopher gave several illustrations. He said we have most excellent standard tables whereby such examinations can be made. Even to take the height and weight of a child is no easy matter. It requires trained men to do this. He believed in a certain amount of child labor. In view of the high degree of modern competition and struggle for existence as well as in view of the welfare of child training, he believed that children have an inalienable right

to work. Their capacity for work, however, depends not upon their age, but upon their physical development. How this is to be determined in every case, the speaker was not prepared to say. With Mr. Mecartney he upheld the dignity of manual labor and therefore advocated earnestly manual work in our public schools.

John M. Dodson took slight exception to the views of Drs. Churchill and Christopher and said that he believed the age standard to be the best in the present existing circumstances. It was not all that could be desired by a long way, but in securing legislation of any sort upon any matter, it was always a difficult thing to do unless there was a uniform opinion or universally applicable standard in existence. There was more of a uniformity both in opinion and in fact in connection with the age test than with the physical capacity test. And in view of this he believed that it would be unwise just now to interfere with the proposed bill. Sometime we may better the conditions and secure even more desirable legislation. Some legislation upon this crying evil is better than no legislation, and just now it is better to adopt the age standard than one about which authorities are still in some doubt. Again, even granting the perfection of the physical capacity method of determining a child's fitness or unfitness to labor in a factory, the age of the child cannot be entirely ignored. It must be taken into consideration along with the physical capacity of the child. In order to bring the whole matter distinctly before the club and to get the assistance of the club directly in the work, he moved that the board of directors of the Physicians' Club of Chicago present at the next meeting of the club an outline of a plan whereby the club can assist the Illinois Federation of Women's Clubs in its pending efforts to secure appropriate legislation.

Mr. Bodine here moved that Dr. Dodson be appointed a delegate from the Physicians' Club to represent it upon this matter at the meeting of the Federation and when the proposed legislation is brought up for consideration. It was so carried.

A. C. Cotton declared that like Mr. Mecartney he believed in child labor. There was too much idleness among American children. As to child labor in factories, he recognized its many abuses and agreed with those most emphatically who spoke for its better regulation. All laws are good, he said, but still there were shortcomings in legislation. How are you going to enforce the laws. We have already seen how they are evaded by false affidavits. And after the laws are made, what then? Indeed, it is a better sentiment in regard to the dignity of labor that is needed in America. Today we are suffering from a sort of laborophobia. People must be taught by precept and example—not by law—that labor is honorable and that even children when properly fitted for it may be allowed to toil in the shops of industry as well as adults. He approved of all measures, legal or otherwise, that may be

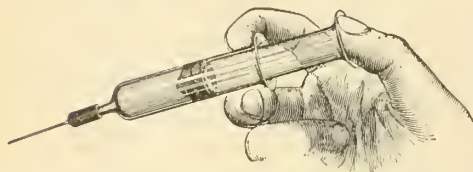
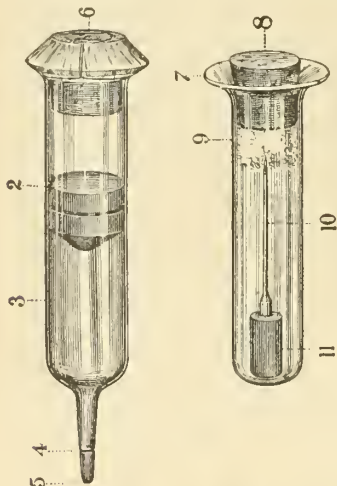


adopted to determine the child's proper capacity for work.

Cornelia B. de Bey, who has taken part in some of the investigations with Mrs. Van Der Vaart, spoke briefly upon the two great deficiencies in American life. The first was the educational deficiency, involving much that is in need of improvement in our public school system and which leads to mental death. The second is the industrial deficiency, involving our great factory and store systems and which leads to physical decay and death. Working together these two will lead to a future race of Americans that will be puny and inferior both in mind and body. It behooves us to be up and doing to correct these evils, while they are beginning to raise their heads so prominently.

L. Harrison Mettler, Official Reporter.

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No. 9.

Springfield, Ill., February, 1903.

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BY SAMUEL C. PLUMMER, JR.

Professor of Operative Surgery, Northwestern University Medical School; Surgeon to Wesley Hospital.

In 1891 and 1892 Hartley of America and Krause of Germany, each working independently, devised a method of resecting the trigeminal nerve intracranially by means of an osteoplastic resection of the skull in the manner originated by Wagner. Hartley's first case was operated upon August 15, 1891 (or as stated in his second article August 8, 1891) and Krause's February 23, 1892. Hartley's case was reported to the New York Surgical Society January 13, 1892; Krause's to the German Surgical Society at its Twenty-first Congress in Berlin, June 10, 1892. Hartley's<sup>1</sup> case was published March 19, 1892, and Krause's<sup>2</sup> October 11, 1892. Thus it is seen that, while Hartley's case was operated upon before Krause's, and also published before Krause's was published, Krause's case was operated upon before Hartley's case was published.

Hartley in a second article on this subject in May, 1893<sup>3</sup>, claims priority for the operation, a claim which, I believe, is not disputed.

Hartley, in his first article, describes his flap as follows: "An Omega-shaped incision was made, having its base at the zygoma and measuring a distance marked by a line drawn from the external angular process of the frontal bone to the tragus of the ear.

"The curved and rounded portion of this incision reached as high as the supratemporal ridge, the diameter of said circle being three inches. The skin and deeper tissues were cut in the shape of the Greek capital letter

Omega. The incision was carried down to the periosteum of the skull in all portions of the incision, except in the straight part at the base; the tissues were then retracted and the periosteum divided upon the bone in the same direction and as far as the straight part at the base.

"With a chisel a groove was cut in the bone corresponding to the divided periosteum. This groove went to the vitreous plate, except at the upper angle over the rounded portion, where it included the vitreous plate.

"A periosteum elevator was here inserted and used as an elevator to snap the bone on a line between the ends of the circular portion of the incision. In this way the breakage occurs along the lower portion of the wound, and a flap, consisting of skin, muscle, periosteum and bone, is thrown down, exposing the dura mater over a circular area of three inches in diameter."

In his second article Hartley<sup>4</sup> says: "I do not find it necessary to complete the Omega cut, as the lower straight part of the Omega incision is unnecessary. The periosteal incision converges upon each extremity beneath the muscle flap for about one-half a centimeter so as to cause a cleavage in the bone when elevated. This part of the periosteal incision is made by retracting the skin and muscle flap slightly upon each side. The point at which the periosteal incisions converge is just at the level of the zygoma."

Krause<sup>5</sup> describes his flap as follows: "The pedicle of the flap lies above the zygoma. The incision begins in front of the tragus, mounts upward bending convexly backward, and then describes an arch about semicircular in form, and proceeds forward likewise convexly to the malar bone, in such a manner that the base of this uterus-shaped flap is  $3\frac{1}{4}$  cm. across, its height  $6\frac{1}{2}$  cm., its greatest width, lying above,  $5\frac{1}{4}$  cm."

It will be seen that this flap corresponds very closely to Hartley's.

\*Read at the 52d Annual Meeting of the Illinois State Medical Society.

Each of these writers intended his flap to be used for intracranial resection of the fifth nerve. However, Krause adds in a foot note to his article: "My incision serves well for the purpose of ligating the main trunk of the middle meningeal artery." Hartley in the description of his first operation says, "The middle meningeal artery was tied," but says nothing of the use of his flap for the purpose of exposing the artery.

In an article by the writer<sup>6</sup>, giving the results of original investigations on the middle meningeal artery, one of the conclusions was as follows: "That we have in the Hartley-Krause osteoplastic flap the only method fulfilling all the requirements for an ideal exposure of the middle meningeal artery and its branches." Although this conclusion was based solely upon my own researches, it was by no means an original conclusion, since Steiner<sup>7</sup> in 1894 concludes that this method is of so great superiority that we now have no use for the more-defined locations of other methods except where some contraindication to the formation of the flap is present. These contraindications he names as the presence of a compound fracture, or great injury to the soft parts.

The method was tested by Steiner as well as by myself upon the cadaver, and the conclusion in each case was based upon anatomical rather than practical surgical considerations. In every case the main trunk and anterior and posterior branches were rendered accessible.

To Kronlein<sup>8</sup> we owe much for classifying the hematomata resulting from rupture of the middle meningeal artery or its branches according to their anatomical locations, and for pointing out definitely the objects to be accomplished in exposing the interior of the cranium in case of such arterial rupture.

Kronlein divides all extradural hematomata originating in rupture of the middle meningeal artery or its branches into I, Diffuse, and II, Circumscribed.

Of the diffuse hematomata he says: "They are of great extent, covering almost the en-

tire concavity of the affected area of the cranium."

Of the circumscribed he says: "They can be extensive, but one part of the dura mater is always adherent to the concavity of the skull. These hematomata have a sharp border, and are generally oval or circular in outline, their greatest thickness corresponding rather exactly to the center."

He subdivides the circumscribed hematoma into three anatomical groups:

1. Hematoma medium, or temporo-parietal.
2. Hematoma posticum, or parieto-occipital.
3. Hematoma anticum, or fronto-temporal.

Of these three the hematoma medium is by far the most frequent. This occupies the middle fossa of the skull, and is generally bounded anteriorly by the lesser wing of the sphenoid, posteriorly by the petrous portion of the temporal bone, reaching inferiorly to near the foramen spinosum and superiorly to, or frequently beyond, the squamous suture. The greater frequency of this group is accounted for by the greater vulnerability of the temporal region and the richness of vessels, this region including the main trunk and anterior and posterior branches.

The hematoma posticum is decidedly rarer. This occupies the region below the parietal eminence, leaving the middle fossa quite free, and reaching generally to the falx cerebri above, to the occipital protuberance behind and to the tentorium cerebelli below.

The hematoma anticum is the rarest of the three. This occupies principally the region of the frontal eminence, separating part of the dura mater from the orbital plate below, and extending posteriorly to or beyond the anterior inferior angle of the parietal bone.

As to the objects to be accomplished in exposing the site of the hematoma Kronlein says: "We have to do in the first place not with checking hemorrhage, but with the removal of the extravasation which is already present and is dangerous. In cases of difficult diagnosis the hemorrhage has gen-

erally ceased at the time of operation." In a second article<sup>9</sup> he emphasizes the judgment that the position of the hematoma and not the anatomical position of the middle meningeal artery must decide the site for opening the skull.

Wiesmann<sup>10</sup> agrees with Kronlein that the removal of the clot is of prime importance.

In regard to ligation in continuity of the artery in the place of election Kronlein, in his first article, says: "It might promise, in case the hemorrhage continued, only a doubtful result, if the vessel lesion lay immediately peripherally in the anterior branches." In his second article he says: "It could be of value only when the artery happened to be ruptured in the place of exposure and both ends could be tied. This would be really, not a ligation in continuity, but a ligation in *loco laesionis*. In all other cases the ligation in continuity has no value. As I showed in 1882 (Wiesmann's<sup>29</sup> case No. 10) a divided middle meningeal artery bleeds from both ends, so that its ligation in continuity could promise no absolute success."

Wiesmann<sup>10</sup> deals curtly with the question of ligation in continuity: "There is no sense in ligating in continuity in the place of election after trephining."

We cannot but agree with these authorities that our first and most important, oftentimes our sole object in opening the skull, is the removal of the clot which by its pressure is threatening the patient's life. The question of the site of operation, then, must rest upon practical surgical considerations rather than upon anatomical; in other words, it is the position of the clot rather than the location of the artery that must guide us. Practically the exposure and removal of the clot leads naturally to the discovery of the arterial lesion, so that the artery can be secured, if still bleeding. Wiesmann<sup>11</sup> notes that frequently the center of the convexity of the clot corresponds rather closely to the site of rupture of the artery.

Where, then, can the clot most certainly be reached? Kronlein<sup>12</sup>, in his first article, recommends that where there is no sign of value on the skull or its coverings, as a

routine practice we trephine first in the temporal region at about the anterior inferior angle of the parietal bone; in other words, at the location of choice for the ligation of the middle meningeal artery. Here we, as a rule, reach the anterior branch. His reason for choosing this site he states as follows: "We can, almost without exception, succeed in finding here the diffuse hematoma, and the circumscribed temporo-parietal and fronto-temporal. Only the circumscribed parieto-occipital hematoma cannot be reached from this place."

If, then, feeling sure of the diagnosis, the surgeon fails to expose the hematoma by trephining in the temporal region, he must assume that he has to do with a circumscribed parieto-occipital hematoma. In such a case Kronlein recommends that the surgeon proceed to a second trephining under the parietal eminence.

In his second article Kronlein<sup>13</sup> modifies his advice slightly, advising that the choice as to which place to trephine first and whether to combine one trephining operation with another, and, in such a case, in what order, must be decided by exact observation of the patient before and during the operation.

In this article he reports a case where he trephined primarily below the parietal eminence. He was led to do so through having an accurate statement that the patient struck the back of his head on a beer barrel, and by finding a slight suggillation a little to the left of the middle line in the occipital region. In this case the clot was exposed immediately at the trephine opening, but was not entirely removed as it extended so far toward the base as to be out of reach. The patient did not regain consciousness and developed a broncho-pneumonia which was the immediate cause of death. The autopsy showed that the hematoma extended to within 1.5 cm. of the foramen magnum. Kronlein recommends that in such a case an additional trephine opening should be made in the occipital region, somewhat behind the mastoid process in the middle of the inferior curved line of the occipital bone.



How accurate a localizing diagnosis is possible? Sir Astley Cooper<sup>14</sup> said: "I do not find any difference of symptoms produced by the different situations of the blood; whatever is the situation of the blood, the symptom of compression is the same."

Wiesmann<sup>15</sup>, however, points out a number of localizing symptoms which may be observed at times. Thus an isolated paralysis of the opposite arm would point to the middle part of the central convolutions, as the seat of the lesion; an isolated or very strongly marked facial paralysis points to an extravasation low down anteriorly. Unilateral disturbances of sensibility point with great probability to a hematoma posticum. Aphasia, a rare symptom, is due to pressure on Broca's convolution on the left side and points to a hematoma anticum or a very large hematoma medium. The pupillary symptoms are very variable, but when they differ on the two sides, the dilated pupil is on the affected side in the majority of cases, but not invariably. Choked-disc, if present, is on the side of the lesion. Disturbances of innervation of the eye-muscles are generally due to direct lesion or pressure within the cranial cavity, and so may assist in localizing the lesion.

Unfortunately it is only exceptionally that findings leading to an accurate topical diagnosis are demonstrable. Kronlein<sup>16</sup> says: "If the surgeon could see the case from the time of injury and follow the development of symptoms, and if the case were not complicated by concussion of the brain, contusion of the brain, apoplectic foci in the brain substance or acute alcoholism, then we could hope for more in the direction of topical diagnosis. But how seldom are all these conditions fulfilled! In complicated cases without history the surgeon is glad to make a diagnosis in general, or to know on which side to trephine. We think that in the preponderating majority of cases a further refinement of diagnosis cannot be thought of."

In his second article Kronlein,<sup>7</sup> says: "In closed skull coverings we have only the brain symptoms to lead to a diagnosis, and we are generally lucky, if we can tell upon

which side the lesion is. Sometimes we can go a step further and make a probable diagnosis of the location of the hematoma in a certain region. When this is accomplished, it is all that we can do in the way of exact diagnosis."

The most important help in deciding upon which side the lesion lies is the gradually appearing hemiplegia, which may be preceded first by spasms, then by paresis. Difficulty in deciding which is the paralyzed side arises in cases of deep coma. It is claimed by some observers that instead of the usual paralysis of the side opposite the lesion, the so-called 'contralateral hemiplegia, we may have paralysis of the same side as that of the lesion, the so-called collateral hemiplegia. Oppenheim (quoted by Wiesmann<sup>18</sup>) looks upon these cases with suspicion as to the accuracy of the observations.

It appears, then, that in the great majority of cases we can determine upon which side the lesion is, and nothing further as to its location; also, that the great majority of the hematomata can be reached by opening the skull in the temporal region at about the anterior angle of the parietal bone. Hence it is seen that the best site for opening the skull, based upon practical surgical considerations, coincides with that best adapted for reaching the anterior branch of the middle meningeal artery, based upon anatomical considerations.

In my former article<sup>19</sup> I said: "I regard the (Hartley-Krause) osteoplastic flap as the ideal method of reaching the middle meningeal artery, for by it the removal of the clot, which is generally present when this operation is done, is facilitated, and the artery can be ligated in the most desirable location." On the strength of Kronlein's practical deductions, I wish here to reaffirm and emphasize this statement, since by this method we expose the temporal region better than by any other.

An advantage of the osteoplastic flap which has not been alluded to is that it leaves no bony defect. At the time of operation the dura is removed some distance from the inner surface of the cranium by the presence of the clot. Upon removal of the clot the

brain does not at once expand and press the dura back into its normal position; sometimes this process requires several days. As a consequence of this, portions of bone removed by the trephine, ehisel or rongeur forceps cannot be replaced, as there is nothing to support them from beneath. The bone in the osteoplastic flap, on the contrary, can easily be made to resume and retain its normal position.

Kronlein says that a trephine opening in the temporal region will not expose a hematoma posticum. In Fig. 2 I have outlined the flap upon Kronlein's diagram of the three hematomata, and it will be seen that its posterior-superior border touches the edge of the hematoma posticum. Of course this hematoma has no definite limits, but if it is of comparatively large size and extends pretty well forward, its anterior edge will be exposed at the posterior-superior border of the flap, as shown in my second case here reported. If no hematoma is exposed, upon turning down the flap, the opening may be enlarged toward the parietal eminence, or the hematoma posticum may be sought for by a trephine opening in that region, as Kronlein suggests.

The cases in which no clot is present in case of torn middle meningeal artery are, first, those rare ones mentioned by Wiesmann<sup>20</sup> in which the artery does not bleed, and, second, those in which there is a compound fracture which permits the blood to escape externally.

The artery is always found beneath the clot, adhering to the dura. Hartley<sup>21</sup> called attention to this adherence of the artery to the dura, as did also the writer<sup>22</sup>, who demonstrated a process of the dura covering the outer surface of the artery causing a firm adherence between these two structures and inferred "that in cases of extradural hemorrhage the artery would be found beneath the clot in all cases."

So far as I know, every observation, operative or post-mortem, in cases of extradural hemorrhage has borne out the correctness of this inference. A possible exception can be imagined where the artery might be "held

in contact with the bone by running in a canal."

In a considerable percentage of cases, sixty per cent, according to my findings<sup>23</sup>, thirty-eight per cent according to Steiner<sup>24</sup>, the artery runs for a short distance at the anterior inferior angle of the parietal bone in a bony canal, and in such cases it is ruptured in turning down the flap. This, however, as pointed out by Hartley and the writer, is not of serious moment, as the ruptured end is in full view and easily secured.

The earliest recorded case which I can find of osteoplastic resection of the skull for intracranial hemorrhage was reported by Stenzel<sup>25</sup>. The flap he describes as follows: "A pedicled flap 3 to 4 cm. in diameter was made beginning 3 cm. back of the external angular process of the frontal bone." Thus it is seen that his flap, while exposing the same region as the Hartley-Krause flap, was smaller than the latter. This exposed the extravasation which lay somewhat below and behind. Clot removed with the fingers; hemorrhage began again; source could not be found. Iodoform gauze packing. Recovery.

It is not certain that this was a hemorrhage from the middle meningeal artery. Stenzel's diagnosis was "hemorrhage following fracture of the base."

In discussing this case Kranse said: "For ligating the main trunk of the middle meningeal artery I recommend the same flap which I proposed for trigeminus resection."

Steiner<sup>26</sup> says that in 1893 Wolfer used the osteoplastic flap for middle meningeal hemorrhage, and in a second case used a flap 5 cm. broad and 8 cm. high.

Wiesmann<sup>27</sup> says that Nasse also used the osteoplastic flap for middle meningeal hemorrhage.

Case I. Rupture of right middle meningeal artery, anterior branch. Subcutaneous fracture of squamous portion of temporal bone and of base of skull. Compression of brain. Hematoma medium. Hemorrhage into fourth ventricle. Free interval. Contralateral hemiplegia preceded by spasms. Osteoplastic resection of skull. Removal of clot. Ligation of ruptured artery. Death

ten hours after injury. Ante-mortem temperature 107° F.; post-mortem 109.5° F.

P. C., Age 35. Male.

On February 3, 1899, fell through a trap door, striking his head upon the wooden floor about twenty feet below. Did not become immediately unconscious. Was put in a patrol wagon and was seen on his way home by a physician, who found no apparent serious condition present. About an hour after the injury he became unconscious. Shortly afterwards he was seen by Dr. Guy Gowen, who sent him to Wesley Hospital. When seen by Dr. Gowen he had spasms in the left upper extremity, which were soon followed by paralysis of that member.

When seen by the writer at the hospital five hours after the injury he presented all the cardinal symptoms of middle meningeal hemorrhage, compression-pulse, stertorous breathing, left hemiplegia, with history of a free interval and spasms preceding the hemiplegia. In the right temporal region was a slight doughy swelling. Pupils equal, medium dilatation. Temperature 101.5° F.

Diagnosis before operation, hemorrhage from right middle meningeal artery, compression of brain, with probable fracture of skull in temporal region.

Operation five hours after injury. Hartley-Krause osteoplastic flap made on the right side. A hematoma was found in the temporal muscle. In cutting through the bone the Devilbiss forceps, which acts upon the same principle as the Stille forceps, was used. The squamous portion of the temporal bone showed a linear fracture. Upon turning down the flap a hematoma medium was found. After removal of the clot the proximal end of the ruptured anterior branch of the middle meningeal artery was seen to be bleeding freely and was ligated. It was now seen that the fracture extended to the base of the skull. Soon after the operation was begun the rectal temperature of the patient was found to be 104° F., and this continued to rise rapidly, so that at the close of the operation it was 107° F. The removal of the clot caused no change in the condition of the patient, which steadily grew worse. The dura remained depressed, and

a fractured portion of the bone of the flap, which had but poor connection with the soft parts, was removed. Wound closed.

Three hours after the close of the operation the patient died. The post-mortem temperature was 109.5° F.

Operative diagnosis, rupture of the anterior branch of the right middle meningeal artery; hematoma medium; compression of brain; fracture of skull in temporal region; fracture of base of skull.

Autopsy. Six hours after death I had the privilege of examining the skull and its contents. There had been no further hemorrhage from the middle meningeal artery. The fracture extended across the squamous portion of the right temporal bone, across the great wing of the sphenoid on the right side, through the body of the sphenoid and into the great wing of the sphenoid on the left side. In the fourth ventricle was found a clot almost one-half centimeter in diameter.

Post-mortem diagnosis. Same as operative diagnosis, with the addition of hemorrhage into the fourth ventricle.

Immediate cause of death, hemorrhage into the fourth ventricle.

Case II. Subcutaneous linear fracture of parietal bone above right parietal eminence. Rupture of several small branches of middle meningeal artery in this location. Concussion of the brain. Compression of the brain. Hematoma posticum. Partially free interval. Contralateral hemiparesis. Osteoplastic resection of skull, with enlargement of the opening upward and backward. Removal of clot. Iodoform gauze packing. Recovery.

J. K. Age 30. Male. Horse-shoer. Family history negative. Previous health good.

On August 11, 1901, at about 5:30 P. M., while slightly under the influence of liquor, fell from a balcony, a distance of 8.5 feet, striking his head upon a concrete pavement. Became immediately unconscious, and was taken to Wesley Hospital twenty minutes after the reception of the injury. Was totally unconscious when he entered the hospital, but three-quarters of an hour after the injury he became partially conscious and could



answer questions. The period of semi-consciousness was short and he gradually lapsed into complete unconsciousness. At the same time paresis of left arm and leg developed, and the pulse gradually lowered. At 6:15 P. M. the pulse was 82 per minute; at 7:30 P. M. 64, and at 10:30 P. M. 52. It was the characteristic full, compression pulse. Pupils equal, medium dilatation. No fracture could be discovered; no wound or contusion of soft parts.

Diagnosis before operation, hemorrhage from right middle meningeal artery; compression of the brain.

Operation six hours after injury. No sign of injury to the scalp. Hartley-Krause osteoplastic flap made on the right side, as in Case I. No injury to the bone found in this neighborhood. Upon turning down the flap the anterior branch of the artery, which was in a bony canal on the flap, was ruptured and ligated. At the upper posterior part of the exposed area was seen the edge of a hematoma. An incision through the soft parts was now made upward and backward 2.5 inches, beginning at the upper posterior margin of the flap. This brought to view a linear fracture of the parietal bone two inches long, running parallel with the sagittal suture and lying 1.5 inches below the suture. No depression. With the Devilbiss forceps a portion of bone 1 to 1.5 inches wide was removed throughout the entire length of the incision through the soft parts, its upper posterior extremity being above and a little behind the parietal eminence, and reaching to within 1.5 inches of the sagittal suture. This exposed the hematoma thoroughly, and the clot was removed with the fingers and the sharp spoon. A number of small branches of the middle meningeal artery were found bleeding beneath the site of the fracture. The dura was intact. Iodoform gauze packing. Weight of clot 2.5 ounces. The portion of bone removed from the parietal region was not replaced.

Operative diagnosis: Subcutaneous linear fracture, without depression, of right parietal bone above parietal eminence. Laceration of several small branches of the mid-

dle meningeal artery. Hematoma posticum. Compression of the brain.

Post-operative history: Pulse at the close of operation 122. Two and one-half hours after the operation he answered questions and moved his left leg; pulse 132; axillary temperature 100 F. Four and one-half hours after the operation he was fully conscious. The highest temperature was twenty-four hours after the operation, 100.8 F. in the axilla. On the fourth day the temperature became normal and remained so. The pulse became normal on the third day. Thirty hours after the operation the outside dressings were removed, being saturated with blood and serum. Fifty-six hours after the operation the gauze packing was removed, and fresh packing was inserted in greatly lessened amount. The wound was aseptic. Five days after the operation all packing was removed permanently, the dura now being everywhere returned to its normal position. For four days the patient had to be catheterized. His progress after the fifth day was uneventful.

Present condition: He has been working steadily at his trade of horse-shoeing, but says he occasionally has pain in the scar when he stoops over at his work. The cold also makes the scar smart. The anaesthesia which at first was noticed in the scalp above the scar has disappeared. He has no headache, no vertigo, no periods of unconsciousness. The scar shows the height of the flap to be three inches, and its greatest breadth three and one-half inches.

These two cases confirm Kronlein's<sup>23</sup> observation that the result of operation for hematoma arising from middle meningeal hemorrhage is generally favorable unless compromised by simultaneous injuries resulting from the same cause as the hemorrhage. In Case I, if the extradural hematoma had been the only trouble, recovery could have been looked for, but the patient died from the concomitant hemorrhage into the fourth ventricle. The second case, being uncomplicated, recovered.

Wiesmann<sup>29</sup> reports several cases of extremely high temperature in hematoma from the middle meningeal artery. In several

of the cases this was due to intercurrent causes, as erysipelas and broncho-pneumonia. In others, the decomposition of the clot, where this had not been removed, account for it. The cases similar to Case I, in which the temperature rises to an extreme height in a few hours after the injury, he regards as not yet satisfactorily explained, not accepting as proven the theory of direct irritation of the heat-regulating center.

#### *Bibliography.*

1. Hartley. Intracranial Neurectomy of the Second and Third Divisions of the Fifth Nerve. A New Method. New York Medical Journal, March 19, 1892.
2. Krause. Resection des Trigemini innerhalb des Schadelhohle. Archiv fur Klin. Chirurgie, Band XLIV, Heft 4. Oct. 11, 1892.
3. Hartley. Intracranial Neurectomy of the Fifth Nerve. Annals of Surgery, Vol. XVII, p. 511, May, 1893.
4. Loc. cit.
5. Loc. cit.
6. Plummer Research on the Surgical Anatomy of the Middle Meningeal Artery. Annals of Surgery, Vol. XXIII, pp. 540-572, May, 1896.
7. Steiner. Zur chirurgischen Anatomie der Arteria meninge media. Archiv fur Klinische Chirurgie. Band XLVIII, I, 101.
8. Kronlein. Ueber die Trepanation bei Blutungen aus der Arteria meninge media und geschlossenen Schadelkapsel. Deutsche Zeitschrift fur Chirurgie Band XXXII, 1886.
9. Kronlein. Weitere Bemerkungen uber die Lokalisation der Hamatome der Arteria meninge media und deren operative Behandlung. Beitrage zur Klinischen Chirurgie. Band XIII. Heft 2. 1895.
10. Wiesmann. Handbuch der praktischen Chirurgie, von Wiesmann, Bergmann u. A. Stuttgart, 1899. Band 1. S. 225.
11. Wiesmann. Loc. supra cit. S. 212, 213.
12. Kronlein. Zeitschrift f. Chir. Loc. cit.
13. Kronlein. Beitrage z. Klin. Chir. Loc. cit.
14. Cooper. Lectures on Surgery. London, 1832, p. 126. Quoted by Kronlein, Zeitschrift f. Chir. Loc. cit.
15. Wiesmann. Loc. supra cit. S. 218, 222.
16. Kronlein. Zeitschrift f. Chir. Loc. cit.
17. Kronlein. Beitrage z. Klin. Chir. Loc. cit.
18. Wiesmann. Loc. supra cit. S. 219.
19. Plummer. Loc. cit., p. 570.
20. Wiesmann. Loc. supra cit. S. 212.
21. Hartley. Annals of Surgery. Loc. cit.
22. Plummer. Loc. cit., p. 541.
23. Plummer. Loc. cit., p. 554.
25. Stenzel. Vorstellung eines Falles von temporaren Meisseltrepanation wegen Blutung nach Basisfractur. Verhandlung der Deutschen Gesellschaft fur Chirurgie XXII Congress, Berlin, 1893.
26. Steiner. Loc. cit.
27. Wiesmann. Loc. supra cit. S. 227.
28. Kronlein. Zeitschrift f. Chir. Loc. cit.
29. Wiesmann. Ueber die modernen Indicationen zur Trepanation mit besonderer Berucksichtigung der Blutungen aus der Arteria meninge media. Deutsche Zeitschrift fur Chirurgie. Band XXI u. XXII. 1884 u. 1885.

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#### TETANUS—A CASE—RECOVERY.\*

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BY F. E. WALLACE, M. D., MONMOUTH.

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It is a well known fact that the germs of tetanus are found in great numbers in the superficial layers of the soil and that those who are uncleanly of habit or by necessity laboring in uncleanly places, are most often the victims of the disease.

Tetanus bacilli are strictly of anaerobic nature and grow rapidly under these conditions.

Because of their abundance in the earth they easily gain admittance to the intestinal tract of grazing animals, and although they

\*Read before the Illinois State Medical Society, Quincy.

have become attenuated by the influence of sunlight and air, in this natural incubator their virulence is enhanced. They enter a comparatively harmless and non-toxic bacillus and emerge toxic and dangerous.

It is readily seen that the germ is found in abundance in the dung of animals. In my case report you will see the connection with this fact.

Recent experiments at Behrings institute show that the supremely toxic tetanus toxine is entirely harmless to the organism from the alimentary canal. It is not absorbed either from the stomach or intestines but passes unaltered through the entire canal and is thus eliminated *per anum*.

It is evident from their common occurrence that the spores must find entrance to many wounds, in which they do not develop. Tetanus is more common after a punctured or contused wound than an incised one. This probably is true because in a contused wound the bruised tissues, stagnant blood and the presence of other infectious germs favor their growth, while an open wound admits of free entrance of oxygen and the profuse bleeding flushes out the germs.

The true chemic nature of the poison has not been determined. It acts through the nervous system and its characteristic effects are caused by the toxine and not the germ itself. The germ multiplies at the point of entrance and as a rule is not widely disseminated. It is possible for them to multiply and produce their effect without giving rise to any local reaction.

They are two reasons why the incubation period varies. 1st. Because of the germ being anaerobic. 2d. The susceptibility of individuals. The bacilli may have entered the wound after long exposure to light and air. It is now, however, in its proper sphere for growth. Its toxins are produced in ratio to its attenuated condition on entrance. It is obvious that one individual may be more susceptible than another. The toxine is absorbed chiefly through the lymphatics, only a relatively small quantity enters the vascular system. It increases the pulse rate and pressure, and respiration is rendered systematically slower. The in-

creased pressure is not proportional to the dose of toxine but is closely connected with the contractions of the muscles. Section of the medulla in the neighborhood of the cervical enlargement has the effect of arresting this pressure, so it is readily seen to have some connection with the bulbar vasomotor centre.

The nerve cells of the motor horns of the spinal cord have shown lesions or changes.

The cerebro spinal fluid undergoes no change during the course of the disease. No bacilli have ever been found in it and inoculation experiments with it gave negative results.

Cases have been reported in which the tetanic symptoms have disappeared with the appearance of the rash of measles and scarlet fever, and with violent diarrhea, etc., but in these cases we may rightly doubt the diagnosis. The tetanic symptoms most probably come from the disease which intervened.

Pronounced trismus seems to be the only sign pathognomonic of tetanus.

G.—Tizzoni announces that inoculation with pneumococcus vaccine not only protects rabbits against pneumococcus infection, but also against the smaller fatal doses of tetanus. Tetanus vaccine also renders the animal more resistant to pneumococcus infection, but does not save it from death at last.

A few cases of the disease have followed seemingly clean operations where the wounds have united by first intention and where there was no localized manifestations of infection. These cases are hard to understand and we can only theorize as to the probable cause.

We see mention made occasionally of a so-called idiopathic case. This of course we cannot take in its literal meaning, for in all cases infection is through some wound, although we may not be able to locate it. The treatment is based on the following principles:

- 1st. Removal of all germs at point of entrance.
- 2d. Elimination of toxins.
- 3d. Neutralization of toxins.
- 4th. Control of painful spasms.
- 5th. Sustentation of patient's strength.



Many cases of tetanus could by ordinary cleanliness be prevented. Every wound should be thoroughly curetted and irrigated, after which peroxide of hydrogen should be freely used. It should then be dried and a 1 per cent solution of silver nitrate applied, so that all parts of the tissues may be in contact with the solution for one minute. According to Tilman, a 1 per cent solution of silver nitrate will kill all germs and spores in this length of time. We thus prevent the formation of the death dealing toxine. We show criminal negligence if we do not use the ordinary surgical precautions in caring for our hands and the wound.

I believe there is but one recognized prophylactic treatment, and that is the use of anti-tetanic serum. There is no question but that anti-toxine is of great value as a prophylactic measure and abundant evidence is at hand to show that it is worthy of trial. Many surgeons are using it in cases in which the wound is contaminated with earth, or in their opinion it may contain the germ. It is manifestly impossible to give all cases prophylactic doses of anti-toxine but in such cases as mentioned it is certainly quite surgical. Of course the proper cleaning and dressing of a wound must be considered a prophylactic measure.

There is no need to dwell on the question of elimination, for all practitioners recognize the fact that no treatment is more efficient than elimination, and is just as needful as any specific; in fact makes the specific remedy more potent. Besides, elimination through bowels, kidneys and skin some advise it by bleeding.

Can the toxines of tetanus be neutralized? This question has been the subject of much experimentation for years past, and I believe can from the evidence at hand be answered in the affirmative.

It has been declared that if the infection has already reached the brain the antitoxine is powerless to effect the results inoculated at the periphery, or into the brain itself, and furthermore that if injected into the brain it causes the nerve substance to lose, at least for a time, its natural power to neutralize the poison, thus becoming itself toxic. On the other hand Borrel claims

that by injecting the serum directly into the cerebral substance, small doses will save life where, if injected subcutaneously, enormous doses will have no effect, and furthermore observes that in all cases immunity either acquired or natural depends on the arrest of the toxines before they reach the sensory cells.

The failures of antitoxine in curing tetanus are ascribed by Roux (A. M. J. 9-24-98) to the fact that "the nerve cells have more affinity for the toxine than for the antitoxine and therefore take it up from the blood leaving the latter to circulate ineffectually, unable to reach and neutralize the toxines then accumulated in the nerve cells. The conclusion follows that the antitoxine must be introduced directly into the nerve cells to cure or prevent their intoxication, and this has been accomplished experimentally, arresting the disease at once and holding it stationary until convalescence commences." He cites a case in a boy 16 years old in which the injection was made on the fifth day through trephine openings on both sides of the skull into the base of the second frontal, convalescence commenced on the 7th day after the operation; complete 9 days later.

Other cases are on record resulting in cure by the intracerebral injections. The advisability of this procedure is not upheld by some surgeons, however, claiming it useless and dangerous. The injection of antitoxine acts rather as an immunizing agent than a curative one, and recovery depends largely on its early administration, for as shown by the experiments, after the toxine once reaches the nerve centres the antitoxine does not counteract, or at least but weakly. We must prevent the absorption of the toxine by putting into the blood its antagonist. Injections into the subarachnoid space does not increase the immunizing power, and passes quickly into the blood current.

Three years ago the obstetric clinics of Prague had to be closed on account of an epidemic of tetanus. The number of cases progressively increased for two years previous in spite of disinfections and the subcutaneous injections of tetanus serum which

had been systematically practiced at Prof. Pawlik's clinic as a prophylactic measure.

This illustrates one peculiar feature in the use of antitoxine in tetanus puerperalis, i. e., it does not seem to produce any improvement.

It is a well established fact that the longer the period of incubation the better the chance of recovery.

Some observers have found that tetanus germs are susceptible to cold and that the reduction of temperature interferes with their vital activity and sporulation, and with this idea in view the treatment has been tried with good results. Ice being applied the arrest of progress in development of the disease was manifest in a few hours. This treatment must be continued for several days, or until the symptoms do not return after its withdrawal.

Some cases have been treated by blood letting, and the injection of a normal salt solution, with the idea of diluting and eliminating some of the poison. Antitoxine is then injected to neutralize the poison remaining. This treatment has resulted in some cures. Cases would have to be selected for this treatment, however.

Next to antitoxine stands carbolic acid in the treatment of tetanus. Its use is being urged by many observers, solutions ranging from 2 to 33 1-3 per cent have been used subcutaneously. The indication for its withdrawal is albuminuria or depression of the heart. The interval of dosage is from three to eight hours. As high as twenty minims of a 33 1-3 per cent solution has been used every three hours for six days without albuminuria or depressing the heart—strange to say, recovery took place.

Bacelli's treatment in Rome in 1898 was the injection of phenic acid 2 to 3 per cent solution in doses of  $\frac{3}{4}$  of centigramm. As much as 35 c.g. can be injected in 24 hours. His mortality was two in thirty cases. Whatever treatment is undertaken it must be given with the idea of preventing the toxins from effecting the nerve cells in the higher centres. Experiments have shown that these toxins are taken up principally by the lymphatics, so that it is good treatment to inject the antitoxine intra-venously

so as to reach the higher centres as quickly as possible. It is subcutaneously administered, however, in the majority of cases.

We do not know how much toxine is circulating in the blood current, and we must inject enough to fully overcome the poison. The initial dose should be large, not less than 500 antitoxine units. This not only antagonizes the toxine but helps to overcome the painful spasms and muscular tension as well. If necessary, give morphine, chloral, bromides, etc. Do not allow the patient to suffer. During convulsions chloroform or amyl nitrate can be given. Maintain the bodily strength as much as possible by proper diet and stimulants.

Mortality statistics have usually varied between 50 and 80 per cent. The mortality in the cases treated with Behring's serum has been about 40 to 45 per cent up to 1897.

My experience with tetanus has been limited to five cases. In four of these cases I will briefly outline a history, with results. I give the history only from memory.

1st. A carpenter with a slight abrasion on back of hand. Symptoms came on several days afterward. The tissues surrounding wound were excised and an antiseptic dressing applied. Antitoxine was administered for two or three days, but he died.

2d case. A lad of 16 or 18 years shot himself through the palm of hand. The wound was cleansed and dressed in usual way, and patient sent home. He returned every day for dressings. In a few days tetanic symptoms developed. The antitoxine treatment availed not.

3d case. Boy of 5 or 6 years while playing in the street about 4 P. M. ran into a wagon and was knocked down and bruised and scratched in several places. He was taken home. Five or six hours afterwards he developed tetanic convulsions. He died about 4 or 5 A. M. Antitoxine was not used.

4th case. A carpenter fell from scaffold-ing sustaining a compound, comminuted fracture of the forearm. His family physician was called, made a digital examination of the wound without washing his

hands. The fracture was set and dressed without curetting and irrigating. Only cotton or gauze wet with earbolie acid solution was used in washing out the wound. As this physician was to be out of the city for several days the case was turned over to a colleague. In 6 or 7 days tetanic symptoms developed, ending in death 4 or 5 days later, although the serum treatment was used.

Murphy—"Praetical Medical Series 1901" speaks of an article by Taylor of New York, which says:

"The case fell into the hands of a recent graduate and very possibly the wound was not cleansed as well as it might have been."

I must protest against such statements. I cannot conceive of any recent graduate having any more serious results than followed the treatment of an older practitioner in the last cited case. Recent graduates may make mistakes, but in surgical cleanliness I believe them as careful as any older physician.

In the same article reference is made to two cases in which tetanus followed abdominal section, the wound healing by first intention and without showing indications of other infection. Tetanus therefore can and does follow clean operation wounds, but the fact is most pertinent that too much care cannot be used in our operations and preparations.

5th case. I give the history in detail because of recovery and of many interesting points connected therewith.

A. H., aged 30, farmer. July 5th, 1901, while working with pitch fork a splinter from handle was forced under skin of palmar surface of middle finger of left hand. It bled but little and he went on with his usual work, not taking splinter out. It was a trifle sore next day and he applied a dressing of fresh cow's manure "to keep the soreness out," as he remarked. This was left on several hours. The splinter remained in place five days, when he removed it. But little suppuration was present. The wound healed at once. He did not stop his work. On 14th inst. he had a little drawing pain through back, lasting

but few moments. This occurred again on 17th. On 18th his folks noticed that his eyes were not just right, but could not describe the abnormality. He stated that while eating his jaws seemed a trifle stiff, and once in awhile this twinge or drawing was felt in his back. He said nothing about these symptoms, however, thinking them trifling, and worked as usual. The next two days developed no new symptoms except that he did not feel well and sweat quite freely. He did no hard work but attended to choring. 19th. These peculiar sensations of drawing were marked in jaws and back. Came on only if he laughed or talked, or while eating. Felt all right in the intervals. 21st. These symptoms continued, but came more frequently and seemed to involve more of the muscles of the back, and extended into muscles of abdomen. There was no distinct pain, nor did he seem to be disturbed or alarmed about the symptoms. This is seen from the fact that up to this time he had consulted no physician. He rode three miles, walked into my office the evening of 21st, at which time I secured the above history. When he talked he seemed to be extremely nervous. I noticed he handled himself with great care, making no quick movements. In sitting down or getting up he was quite cautious for fear of bringing on the muscular spasms. Trismus was constant. He could open his jaws and close them slowly without the spasm, but on biting the effect was immediate; marked contractions of muscles of back and abdomen. Patellar reflexes greatly exaggerated, pupils reacted to light, pulse normal, temperature 99.3, respirations normal. Said he felt well and could eat and sleep quite well. At times he had experienced numbness in feet and hands. I did not tell him the true condition. I sent him home and told him to go to bed. Gave him chloral and pot. bromide, 15 gr. each. Ex. hyocyanus and can. ind.  $\frac{1}{4}$  gr. a gentian 1 gr. every two hours. Calomel and salts for cathartie. He slept well that night and felt good. The morning of the 22d about 6 o'clock he had a severe spasm, with marked muscular contractions, copious



sweating, and jaws set firmly. This spell lasted about ten minutes. About 9:30 I was called. E. L. Mitchell was asked to go out with me. When we arrived he was having another attack. Found him lying on his face, sweating profusely. The muscles of back were contracted so as to make opisthotonos marked. The muscles of lower limbs and abdomen were extremely tense. After ten minutes he asked to be turned over. This was accomplished much the same way as rolling a log. The movement did not produce spasm. This was the most severe spell he had had. Complained of some pains in back. Pulse 95, temperature 99.3. I injected 50. min. of a 5 per cent solution of carbolic acid. Continued the chloral and bromide mixture every two hours. Nitrite of amyl pearls were left to be used if any more spasms occurred. Bowels and kidneys active and had a good appetite. Egg nog was given every three hours. No more severe convulsions occurred during the rest of day, although had slight spasms and some pain in back. Muscles of back, abdomen and lower limbs in state of tonic spasm. At 9 P. M. another injection of carbolic acid was administered.

23d. 7:30 P. M. T. 99, P. 96.

Rested well during night. Injection of carbolic acid. He was allowed liquid diet. Free sweating was continuous, except when the symptoms became more severe, the sweating was more profuse. At 3 P. M. the carbolic injection, together with 10 c.c. anti-tetanic serum was administered. This was repeated at 10 P. M. T. 99.4, P. 96. The excretions were free during day. Took all the nourishment sent him.

24th. 7 A. M. T. 98.9, P. 85.

Had a fairly comfortable night. Slight pains and spasms occurring at intervals. Injected serum and carbolic acid. Tonic spasms still present.

3 P. M. T. 99.4, P. 90.

Symptoms somewhat abating, had slept. Injection of carbolic acid.

10 P. M. T. 99.3, P. 76.

Secretions free during day. Was asking for more to eat. Serum and carbolic acid administered.

7 A. M. T. 98.8, P. 82.

Not a good night; rolling and tossing considerably. The muscles seemed less tense and was not having quite so much pain. Injection serum and carbolic acid. Was allowed oat meal and egg.

3 P. M. T. 98.8, P. 70.

Had bread and coffee for dinner. Carbolic acid injection.

10 P. M. T. 98.8, P. 74.

Injection serum and carbo. Complained of the shooting pains in back quite frequently.

26th. 8 A. M. T. 90.6, P. 76.

Had several good naps. Ate oat meal, coffee, egg and bread. Injection carbo. Still complaining of pains in back on moving. Tonic spasms—receding.

3 P. M. Back pains continuing and more severe. Having had no bowel movement or passed urine since 8 P. M., I catheterized him, drawing 20 oz. Sweating quite freely. Pain coming in back every few moments.

4 P. M. Injection morphine  $\frac{1}{4}$  gr.

9:30. Complained of pain in right shoulder and back, pains with twitchings. No urine or B. M. cath. 4 oz.

T. 99, P. 93. Morphine injection  $\frac{1}{4}$  gr.

27th. 8 A. M. T. 99.4, P. 100.

Slept well all night. No twitchings after 11 P. M. Had passed 16 oz. urine during night. Ate coffee, egg, bread and corn starch for breakfast. Inj. carbo. No bowel movements.

11 A. M. Talking and seems a little delirious.

3 P. M. T. 98.8, P. 88.

Inj. serum and carbo. In no pain. Muscular tension lessening. No bowel movements, although gave cathartics.

9 P. M. T. 99.2, P. 85.

Slept most of P. M. Passed urine. Inj. carbo.

28th. 8:30. T. 98.6, P. 84.

Slept quite well, although tossed little and appears drowsy. Inj. carbo. Light diet continued.

4 P. M. T. 98.8, P. 78.

Has talked in sleep. Urine plenty. Does not complain of any special pain. The draw-

ing sensation is still present at times. Muscles relaxing. Inj. serum and carbo.

9:30. T. 99, P. 78.

Bowels moved twice and passes plenty urine. No twitchings or pain.

29th. 8 A. M. T. 97.6, P. 75.

Slept well. Muscle tension about all gone. Inj. nitro G. Dig. and strych. A tablespoonful of whiskey ordered every three hours.

5:30 P. M. T. 101, P. 88.

Urine had been very abundant during day. Inj. serum. Muscles of right arm sore.

30th. 7 A. M. T. 99.2, P. 95.

Slept quite well. No bowel movements. Ordered injection salt sol. into bowels. Complaints of itchiness. Gave calomel gr. x to be followed with salts.

5 P. M. T. 99.4, P. 72.

Bowels moved four times. Urine seems normal. Hives appearing and bothering him greatly. Soda baths and alcohol rubs.

31st. 8 A. M.

Slept some fore part of night. Quite restless after 12. Bowels and urine O. K. Hives all over body. Eyelids swollen. Ordered rectal injections and salts. Sweat bath. Gave ergot and belladonna.

6 P. M.

Hives intense. Rolling and tossing and scratching. No pains in back. No twitchings and muscles seem about normal. Urine and bowels quite free.

Had planned my vacation to commence on August 1st, so turned the case over to Dr. Mitchell, and the history from this date on I take from his notes.

August 1st. 7:30. T. 98, P. 100, Res. 18. Injected carbo. Ordered chloral mixture continued. Sol. soda gr. x every three hours.

6 P. M. T. 99, P. 96., R. 18.

Slightly rigidity. Inj. ant. serum.

Aug. 2d. 7 A. M. T. 98.6, P. 88, R. 18. Carbo inj.

7 P. M. T. 99½, P. 100. Rash nearly all gone. Chloral mixture continued.

Aug. 3. P. M. T. 101 1-5, P. 112. Restless and delirious. No rigidity.

2:30 P. M. T. 102, P. 116. Delirious.

Involuntary evacuation of bowels and bladder. Milk diet ordered.

11 P. M. T. 101, P. 100. Delirium. Morph. and atrop. injection.

Aug. 4. 9 A. M. T. 100, P. 112, Res. 20. Delirium subsiding, restless, rigid abdomen. Urine passed normally. Inj. carbo. and ¼ gr. morphine. Symptoms of general pains.

7 P. M. T. 100 1-5, P. 100. Pass urine normally. Pains in knees and pelvic region. Rigidity over abdomen. Had been restless up to 1 P. M. Inj. carbo. ¼ morph. and atrop. 1-100.

Aug. 5th. 7 A. M. T. 100 2-5. Very weak, pains in back and arms. Opens mouth readily. No rigidity of spinal muscles. Very restless. No delirium. Inj. carbo. and morphine. Chloral mixt.

7 A. M. T. 100 2-5, P. 112. Delirious. Takes nourishment.

Aug. 6th. 7 A. M. T. 101 1-5, P. 120. Very restless night, no sleep. Not now delirious. Sulfonal gr. 15 every three hours.

7 P. M. T. 101, P. 104. Restless all day, not delirious. Sulf. cont.

Aug. 7. 7 A. M. T. 101, P. 100. Delirious, but resting fairly well. 1 sulfonal powd. during night. Takes nourishment well.

7 P. M. T. 100, P. 88. Delirious. Sulfonal contin.

Aug 8th. 7 A. M. T. 100, P. 88. Restless until midnight. Delirious.

7 P. M. T. 99, P. 88. Less delirium.

Aug. 9th. 7 A. M. T. 100, P. 100. Delirium subsiding. Urine normal.

12 P. M. T. 100, P. 84. Delirium gone.

Aug. 10th. A. M. T. 100, P. 100. Takes nourishment.

11 P. M. T. 99 4-5, P. 88. Slight delirium.

Aug. 11. 1 P. M. T. 99 2-5, P. 80.

Aug. 12. 7:30. T. 99, P. 88. Resting well.

10 P. M. T. 100, P. 88. Moved to city in morning. Stood trip well.

Aug. 13. 11 A. M. T. 99½, P. 80. Resting well, no delirium. Next two days some.

Aug. 16. T. 98½, P. 72. Doing well.

Aug. 11. T. 99½, P. 12. From this on he improved in strength and was able to go to Pennsylvania on September 1st. He is now working in a steel mill at heavy labor and he has been for some months.

Experience in the use of antitoxin serum has shown that urticaria may occur after its use. I am not aware that carbolic acid produces this effect, so that we can attribute this rash to the use of the serum, the total amount of which was 100 c.c. As to the cause of the delirium, I cannot satisfy my mind so easily. Carbolic acid of course is a poison, but this symptom is not characteristic of the drug. It acts by selection rather on the respiratory and vasomotor centres. First depressing and then paralyzing. The history does not show this effect. Urinalysis was made every day and at no time was there even a trace of cloudiness of the urine, so we can say it is not probable that the carbolic acid was to blame for the delirium. The amount injected *in toto* was 60 c.c. of 5 per cent solution. Chloral in some persons, instead of sleep causes headache, insomnia and delirious excitement. In this case, however, these symptoms came on after the partial withdrawal of the chloral mixture. The delirium was irregular, one day worse and then again better. If chloral was the cause the effect was not constant. The first five days he received about 180 gr. every 24 hours. It was then reduced to 90 gr. for the next 24 hours. Then for 8 days he received about 100 gr. each day. The dose of Pot. Bromide was the same as above. It is true that the bromides may produce hallucinations if continued long, also incompetence of the sphincters but this action cannot be considered in this case. The delirium was made manifest as the rash disappeared, and continued one week. Involuntary evacuations came with the delirium but did not persist long.

The interesting question arises: What produced the cure? Serum, carbolic acid, drugs, or would the case have recovered without treatment? On account of the length of the incubation period, the case is to be considered as a chronic one, and such cases

nearly always recover under the proper treatment.

It is known that a definite quantity of antitoxine will overcome a definite amount of the toxine. Why is it not possible to determine the amount of toxine in the body? By taking a given amount of blood, estimating the units of toxine in this quantity and multiplying the quantity of blood drawn by the estimated quantity in the body, why not know the exact amount of antitoxine to administer? Why not true of diphtheria also? Science should be able to determine this.

Since writing the above I notice a paper was presented at the annual meeting of Association of American Physicians, April 29-30, by B. M. Balton and Carl Fisch of St. Louis. In this paper they stated that the amount of toxine in the horse serum was determined at intervals by injecting guinea pigs with it; these experiments showed that tetanus toxine appears in the blood before symptoms of the disease are present; that it gradually increases up to within a few days before death, when it rather suddenly diminishes, this diminution becoming more marked until the time of death.

#### *Recapitulation.*

1st. The disease is produced by a germ admitted through a wound, and most generally follows uncleanness.

2d. The incubation period varies because, first, the germ is anaerobic; second, individual susceptibility.

3d. It is the toxine which produced the symptom and not the germ.

4th. It acts through the nervous symptom and produces characteristic symptoms.

5th. The toxins are not absorbed from intestinal tract but through the lymphatics.

6th. There may not be any local manifestations.

7th. Pronounced trismus seems to be the only sign pathognomonic of tetanus.

8th. The treatment is based on, 1st, removal of germs at entrance; second, elimination of toxins; third, neutralization of toxins; fourth, control of spasms; fifth, sustaining the patient's strength.

9th. Cleanliness is next to Godliness.



10th. Primary injections of at least 500 antitoxine units.

11th. Serum acts rather as an immunizing agent though a curative one.

12th. Serum of no avail in tetanus puerperalis.

13th. Intra cerebral injection of anti-toxines is justifiable.

14th. Decrease in mortality.

15th. The later the onset of symptoms the better the prognosis.

### DACRYOCYSTITIS.\*

BY E. E. CLARK, M. D., DANVILLE.

Eye, Ear, Nose and Throat Surgeon to Vermilion County Hospital, Lecturer to the Danville Training School for Nurses.

From my own experience and what I can get from the experience of others, dacryocystitis is a perplexing condition and to the truly surgical mind interesting because of this perplexity, and there are few pathological conditions, that when uncorrected, give the individual more constant annoyance than this. There are few abnormalities that I dislike more to see come into my office.

I shall purposely make this paper short, giving some of my own favorable experiences, and more in order to bring the subject up for discussion by those present, for I think, in the majority of instances, the discussion is of far more value than the paper inducing it.

Dunglison defines dacryocystitis as an inflammation of the lachrymal sac, but the condition I want to keep in mind in this paper is that in which the inflammation has gone on to pus formation either acute or chronic.

In pathological conditions of the lachrymal apparatus less reference is made, in the literature, to dacryocystitis than any other single condition. The last edition of the Year Book on Diseases of the Eye, Ear, Nose and Throat devotes but four pages to the entire lachrymal apparatus and but four paragraphs to purulent conditions. In looking over the index to 1836 volumes of Medical Journals for the past year I

found not one reference to dacryocystitis. The New York Medical Record of February 6, 1901, has a short article by E. A. Pond in which his principle point is the use of a silk string, with a knot, passed through the drainage apparatus and the knot drawn back and forth daily through the construction. The Illinois Medical Journal for February, 1901, has a paper by W. O. Nance on chronic inflammations of the lachrymal apparatus, but these are not dacryocystitis. Two years' file of the Cincinnati Lancet Clinic does not contain a single article on this condition and four years of the Annals of Ophthalmology are without reference to the subject except for two short abstracts. I may have been unfortunate in not getting hold of the right literature, but the less I found on this subject the more interesting it became to me and the more interested I became in the hope of hearing a thorough discussion from men of broader experience than myself.

Why so little is written on this subject I cannot understand unless it is because no one, so far, has a definite and assured plan of treatment to propose, but I find other conditions in which the treatment has been just as unsatisfactory referred to, by various writers, repeatedly in these 1836 volumes I have examined.

The factors and conditions leading up to this pathology are interesting and deserving of much consideration, however when abscess of the sac has developed, far more than the correcting of a refractive error or nasal abnormality is to be done.

As to immediate causation I believe retained secretions, almost always, to be the beginning of subsequent pus formation except in syphilitic and tubercular processes. E. Raehlmann proved histologically that trachomatous dacryocystitis could develop. His specimens showed numerous trachoma follicles in the tear sac. This he says accounts for the frequency of acute dacryocystitis in trachoma. The follicular ulcers of the tear sac also cause the obstinacy of the trachomatous dacryocystitis and the strictures of the sac, so frequently observed in this disease, which are the result of the same process of shrinking as in

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

the conjunctiva. This condition I have never met but possibly would with larger clinical advantages among a lower class of people.

In dealing with treatment I shall leave out all the routine procedures which I have tried repeatedly, sometimes with final success, sometimes with failures, failure possibly because the individual had not the patience to stay with it sufficiently long.

The treatment I want to bring before the society is one that so far as my experience has gone has been radical, however I may have occasion later, and with additional use, to change my views. This experience has extended over a period of four years and until my recent investigation of the subject had not heard or seen a word on its use. I find by referring back to the *Annals of Ophthalmology* of April, 1896, that Froelich speaks of using chloride of zinc with success. My own experience with zinc chloride has, so far, been magical.

My first case under this method was reported to the Vermilion County Medical Society four years ago with subsequent reports as cases came up.

The two cases I shall report cover the range of my experience. All other cases similarly treated followed a similar course.

Case 1. Male, age 30. Dacryocystitis of three years' standing with constant filling up of sac and either discharging or being squeezed into conjunctival sac, swollen lids, angry inflammation of conjunctiva, constant overflow of tears. Treated three months by prescribed methods with absolutely no improvement, when without authority, so far as I then knew, I injected the sac with about three drops of a 20 per cent solution of chloride of zinc. Next day there was quite a violent reaction but the one treatment restored absolutely every function of the drainage system and I have positive knowledge that it has remained so for the four years.

Case 2. Female, age 50. Dacryocystitis six months. When first seen by me a fistula had opened below inner canthus with all the ordinary inflammatory reactions. In this case I used a 10 per cent solution of

zinc chloride one week with a positive result that has continued for over one year. In this case there is a slight epiphora on windy days or under some special emotional excitement.

I should hesitate to advise a 20 per cent solution feeling that one would be safer in not going over 10 per cent except after not being satisfied with the weaker. Froelich used a 5 per cent strength.

My results can only make me enthusiastic in this method of handling dacryocystitis.

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### OPHTHALMIA NEONATORUM.\*

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BY I. L. FIREBAUGH, M. D., ROBINSON.

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The fact that quite one-third of all the blindness in the world is the result of this disease, and that it is safely and almost certainly curable when given early and well-directed treatment, renders its importance sufficiently obvious. In looking over the literature of the subject some years ago the first article that came under my notice was from the pen of William O. Moore, then assistant surgeon of the New York Eye and Ear Infirmary, now surgeon to New York Post Graduate School. It was a scathing arraignment of the profession as a whole for its utter ignorance of the first principles of medicine. Thinking Assistant Surgeon Moore might be a new broom, perhaps, I thought I would let it pass though I confess to a touch of resentment at the time, and also to a mental resolve to investigate and if such were the case to see if I could discover any cause for it.

Inquiry of ten of the leading lights on practice, from Eberle to Anders, developed the following: Eberle, away back in the early thirties, gave a very good portrayal of the disease, saying it was contagious, and also that he had never seen a case coming on soon after birth where the mother did not have leucorrhoea or some other morbid vaginal discharge. His ideas of treatment were by no means bad.

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\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

Watson also described the disease and its treatment, though not so fully. Eight of the ten had evidently never seen a case, for they were dumb as oysters on the subject.

Of ten works on mid-wifery from Meigs in 1842 to "An American Text Book," 1895, only two refer to it in any way. Lusk, in his 1885 edition, disposes of the subject in about ten lines. The "American Text Book" covers the ground fully.

Of ten works on the diseases of children, from Churchill in 1849 to Holt in 1897, only five mention the subject and but three of these treat it in any sort of shape. J. Lewis Smith, edition of 1873, has a good article for the time. Holt has a good article, and Starr's American Text Book does 'he subject full justice.

Only moderately pleased with the result thus far, I interviewed the surgeons, with this result: Druit, away back in 1842, had good ideas of the disease, its cause and treatment, and most of the general works on surgery published since then have articles, some good but most of them more or less deficient. Erichsen, edition of 1873, the leading author and the work most generally recommended at that time, makes no mention of it.

The works on Ophthalmology all treat the subject more or less fully, but they are not any too common in the hands of the general profession even at this date. Moreover it is with the oculist as it is with the surgeon—he is not there. They both get their cases second-handed, and then often only when the disease is far advanced, the eye is more or less crippled and too often the sight hopelessly destroyed. Just why this, one of the most important, and the most curable, of all the diseases of infancy, in which early attention is everything, should be so wholly neglected and turned over to others for treatment, I am at a loss to understand. Is it on account of that old notion that all external medicine is surgery? If so, we pay too much for the whistle. Observe the cost.

Of one hundred consecutive cases in private practice reported by S. C. Ayers, of

Cincinnati, forty-two per cent had implication of the cornea when first seen by the oculist and recovered with permanent impairment of the sight. The fifty-eight per cent were treated through without corneal complication and recovered with normal vision.

Of one hundred consecutive cases treated *from the start* in Cincinnati Hospital and reported by S. C. Ayers, every one recovered without corneal complication and of course with vision as good as ever. Now, we are not all Drs. Ayers, and we may lack some of the manual dexterity of the oculist in treating these cases but we can beat forty-two per cent if we get them at the start. Comment on the above is unnecessary.

The disease is of germ origin, and is invariably the result of infection either from discharges from the birth passages of the mother, the hands of physician or nurse, soiled towels, or another case of the disease. It is not caused by too much light in the baby's eyes, as some have said, but very largely by *lack* of light in several directions. It begins to show in twelve to forty-eight hours after the receipt of the poison. It may develop *in utero* and be far advanced at birth, the infection taking place through ruptured membranes. It is regarded by some as always gonorrheal in origin, while others claim that it may be caused by a simple leucorrhea. The nose and middle ear are sometimes invaded and there may be invasion of the joints, as in gonorrheal rheumatism. It has been described by some in two forms—mild and severe—but in reality there is nothing of the kind. No real line of demarkation exists. Just as in scarlet fever, measles or small-pox we see cases so mild as to amount to only the slightest indisposition, while others are malignancy itself; so in this disease there is every shade, from the most trivial catarrh that is without harm, to the most virulent inflammation, destroying the cornea in a few days. This may be accounted for by the vital resistance of the patient, his hygienic surroundings, and also, perhaps, by the virulence of the poison.



About the third day after birth the baby's eyelids begin to adhere. The conjunctiva is a little red and there may be some clear discharge in the corner. It may prove to be just a little irritation, passing off in a few days. It may amount to mild conjunctivitis, getting well in two or three weeks, or it may grow worse when least expected. If it is to be severe from the start, within a few hours (twelve to thirty-six) the conjunctiva and lids become much swollen, the lids are rigid and purplish in color, the upper overlapping the lower ones, sometimes being everted, the conjunctiva showing as an angry red ridge under the lid. The discharge changes rapidly from clear to muco-purulent and then to purulent, becoming very profuse, gushing from between the lids when separated, or hanging in great beads on the cheek or about the lower lids.

This disease runs its course in seven or eight weeks without treatment. The greatest danger to the cornea is in the first few days, on account of the pressure from tension, but danger abides as long as the discharge. The cause is sufficiently indicated by the above. While the prognosis is good in the great majority of cases under proper management, candor compels me to say that Dr. Ayer's record can not always be reached. In certain cases through some dyscrasia there is a peculiar tendency of the tissues to perish. When such a one is attacked the cornea may break on the slightest provocation and become crippled if not destroyed.

B. A. Randall, of Philadelphia, reports a case of total blindness resulting in a patient where every prophylactic measure had been fully and carefully carried out and where there could be no question as to the treatment.

One danger comes from the fact that the average physician may not see more than two or three severe cases in a lifetime of practice. He may have seen several mild cases get well almost without treatment and is off his guard and the mischief is done before he realizes it.

Treatment should be largely preventive. The disease has almost been banished from hospitals by prophylaxis in the shape of

aseptic and antiseptic mid-wifery and the use of Crede's method, which consists of dropping one drop of a ten grain solution of nitrate of silver in each eye as soon as the babe is born.

It is said to be harmless except now and then in very small and immature children. Two and a half to five grains solution of silver is said to do just as well. Some advocate dusting powdered iodoform into the eyes.

Dudley S. Reynolds, of Louisville, Ky., condemns the Crede method without stint, pinning his faith to cleanliness for prophylaxis and irrigation in gonorrhoeal cases with a solution of

Common salt ounces, iii,  
Bichlorid of mercury, gr. iv,  
Carbolic acid, gr. xvj,  
Water, Cj,

filtered and used every half hour night and day sleeping or waking during the purulent stage. If there is much chemosis with swelling and tension of lids in the early stage free external canthotomy is recommended. Kalt recommends irrigation with a solution of permanganate of potash 1 to 5,000 used three times a day until the disease yields, using two quarts at a time. While according to Miles Standish, of Boston, the usual custom in the Massachusetts Charitable Eye and Ear Infirmary is to flush out the conjunctival sac every three hours with a twenty per cent solution of protargol during suppuration, with distinctly better results than are produced by nitrate of silver.

Let every work on mid-wifery, diseases of children, and practice for that matter, have an article on the subject covering the ground fully. Let students of medicine have more clinical and less didactic teaching. In other words let them *see* cases and their treatment rather than hear of them. The mild cases require very little, good hygiene and cleanliness doing the work. All cases should be watched and cases of any severity should have close attention. Since all discharges are contagious, care must be taken to prevent the infection of others, the physician not forgetting his own eyes.

Wash the eyes frequently with borie acid solution. If lids are very hot and tense use cold applications, pieces of lint transferred from a block of ice to the eye as fast as they get warm. They should be changed every two or three minutes and only be used an hour or two at a time, the cornea being watched carefully lest we cause just what we are trying to prevent. Cold applications can be used in this way until the purulent stage is reached, but must be stopped at the first indication of corneal ulceration. As the discharge grows profuse, it must be removed every half hour or hour either with pieces of absorbent cotton or by irrigation with sterilized water or some mild antiseptic solution, the lids being separated for the purpose. Once a day at least, the physician must take the patient's head between his knees, face up, the lap being protected by some impervious covering, evert the eyelids, cleanse the whole conjunctiva and treat it thoroughly with nitrate of silver, five to ten grains to the ounce, washing it off immediately with water or solution of common salt. This should begin when the discharge becomes profuse and be continued while it lasts.

No instruments are needed except a wall syringe, a glass dropper for a nozzle and the fingers—which are always on hand. Weak astringents can be used, as collyria, between times, but nothing can take the place of cleanliness. If the cornea should be invaded use eserine, one-fourth grain to ounce of water, or atropine one grain to the ounce of water as indicated by position of ulcer.

By good management these cases get well in three or four weeks. Christian Science and Osteopathy have no place whatever in the treatment of this disease; suggestion only as it applies to the attendant, and prayer only as its fruit is made manifest by earnest labor upon the lines above indicated.

Eternal vigilance is the price of success. The work must be done. Let us give these buds of promise earnest attention. It only occurs two or three times in a lifetime of practice. Though there is little in it to us there is *light* in it to them. Depend on no

one. Let us do these things ourselves and my word for it, we will furnish no recruits for this army of darkness.

### NEPHRITIC EYE LESIONS.\*

BY WILLIS O. NANCE, M. D., CHICAGO.

One of the Assistant Surgeons at the Illinois Charitable Eye and Ear Infirmary; Professor of Ophthalmology, Chicago Clinical School.

Of the morbid ocular changes met with in kidney disease, there is certainly none of greater clinical importance than that which is commonly designated "albuminuric retinitis." This condition manifests itself in more than ten per cent of cases, and when typical, forms a symptom of diagnostic value second only to urinalysis. Moreover, as a prognostic factor in a given case, its presence is a matter of paramount interest.

The other ocular manifestations of renal disease, while less pathognomonic than those just suggested, are of more or less importance, and their brief mention appears to be warranted.

There seems to be no vascular structure of the eye that may not at some time during the course of the malady, be the seat of renal involvement. Besides, the retina, the conjunctiva, the uvea, the lids, and even the external ocular muscles may show signs of remote pathological processes, directly or indirectly attributable to the nephritic condition.

Swelling of the eyelids—particularly the lower ones—is a symptom so suggestive of renal trouble as to invite consideration in this connection, by not only the profession, but the laity as well. It is, at times, an early symptom of acute Bright's disease, in which case the edema is likely to be transient; it is also met with in the late period of chronic nephritis.

Chemosis, or swelling of the conjunctiva, is sometimes observed in connection with nephritis, and its presence, when unaccompanied by severe local inflammatory pro-

\*Read at the 53d Annual Meeting, Quincy, May 20, 1902.

cesses, should lead to careful examination of the urine.

Recurring subconjunctival hemorrhages in persons over forty years of age should be looked upon with suspicion. The hemorrhages occur suddenly, the patient oftentimes awaking in the morning to find a deep red blotch clearly outlined upon the white scleral background. The ecchymosis clears usually within a few days, and there may be no further extravasation for several weeks or months. This symptom I believe to be one of considerable import, and in a number of instances has proven the presence of chronic nephritis, hitherto unsuspected.

Primary iritis occurs in a certain number of nephritic cases, and where no syphilitic or rheumatic history can be clearly demonstrated, renal disease may be looked for. Von Michel, as the result of investigations to determine the causation of primary iritic inflammation, found in 84 cases that over one-third had chronic nephritis.

Paresis of the several extrinsic ocular muscles—due to sclerosis of the nerves, or to a hemorrhage at their origin—not infrequently occurs in the final stages of chronic renal inflammation. The strabismus is apt to be transient and recurrent.

Diminution in the power of accommodation in those past middle life, requiring frequent change of glasses for near work is a symptom of kidney disease well advanced, and should lead, in every instance, to a chemical and microscopical examination of the urine.

The connection between cataract and kidney disease is a matter upon which observers are not fully agreed. Becker, who gave the subject much study, consulting the records of 250,000 autopsies, concludes, that while cataract may occur with renal disease, it cannot be held to be the result of the malady.

Of far greater consequence, however, than any of the manifestations just mentioned, are those intraocular lesions so clearly demonstrable by the ophthalmoscope, and which when noted, form collectively a group of symptoms so pathognomonic as to rank

among the most exacting signs in scientific medicine. The changes commonly met with consist of retinal edema with dark red hemorrhages, white patches arising from fatty degeneration of retinal fibres and areas of exudation, dilated and tortuous veins, and in most instances, a swollen nerve-head. These lesions are usually seen contemporaneously and constitute the commonly designated "albuminuric retinitis," or what may be more specifically termed "neuro-retinitis nephritica." The condition is one which never appears before the renal affection, but after the disease is well advanced. The eye symptoms may, however, be the first to call attention to the general malady, and it is a common incident in the practice of every ophthalmologist to discover the first traces of kidney trouble in patients complaining only of failing vision. The diminution in the acuity of vision usually occurs gradually, the patient reporting his inability to see objects clearly—the terms "blurred" and "smoky" being used to describe the condition. The color sense remains unimpaired, the visual field is little, if at all, contracted, but central scotomata are the rule. Both eyes are generally affected, although not to the same degree. Unilateral Bright's retinitis is said to be not very rare, although in a rather large clinical experience, I do not recollect ever seeing a case in which one eye remained unaffected for any length of time. Albuminuric retinitis may occur in any of the several forms of renal disease, but is found to be more frequently associated with the granular kidney or in primary atrophy of the kidney.

The course of the affection is variable, depending largely upon the renal disease. There may be periods of marked improvement, and then again sudden exacerbations with greater or less degree of amblyopia. Blindness very seldom, if ever, results, death occurring before such a condition manifests itself.

In this connection is brought out one of the most important clinical facts in the consideration of this subject, i. e., the prog-



nostic significance of neuro-retinitis nephritica.

To the oft-quoted statistics of Belt, who records 419 cases, of which 72 per cent died within one year and 90 per cent in two years, may be added the combined statistics of seven other observers (*Arch. Oph.*, Jan., '02, pp. 99), whose average rate of mortality within two years was 76 per cent, and my own cases, more than twenty in number, none of which has survived more than thirty months.

In reference to these statistics, it may be well to emphasize the fact that all cases of retinal disease occurring in the acute nephritis of the exanthemata, in which the prognosis is much more favorable, have been excluded.

These facts would at least tend to point out the very unfavorable prognosis of cases presenting this ocular lesion, and to direct attention to the importance of a thorough ophthalmoscopic examination in every case of suspected renal disease.

There still remains to discuss one other ocular manifestation of kidney disease which is sometimes confused with albuminuric retinitis, but which differs so clinically from it, as to make the diagnosis clear to any competent observer. The condition referred to is uraemic amaurosis, or more properly, nephritic amaurosis or amblyopia, more commonly met with in the acute nephritis of pregnancy and scarlet fever, but at times developing in chronic renal inflammation during an acute exacerbation of the malady.

The onset of the attack is usually rapid and accompanied by cerebral symptoms more or less pronounced, the patient oftentimes becoming blind within a few hours, the condition lasting from one to two or three days. In uncomplicated cases there are no ophthalmoscopic findings. The condition is one dependent entirely upon defective elimination, and may be looked upon as a true toxæmia.

In treating of this particular subject, it has been my aim to point out the more significant ocular manifestations of nephritis and to allude to their clinical symptoms. In conclusion, I desire to strongly urge upon

the general practitioner the importance of a more general employment of the ophthalmoscope as an aid to medical diagnosis, and a more comprehensive recognition of certain ocular symptoms, which, in many instances, are but the manifestation of morbid processes in organs far remote.

#### Discussion on the Papers of Drs. Clark, Firebaugh and Nance.

**A. H. Andrews**, of Chicago: Mr. President—The paper on ophthalmia neonatorum, and the one on nephritic eye lesions are of special importance to us, and especially do I consider them so for general practitioners. The subject of nephritic eye lesions is not only of interest to the oculist, but to the general practitioner and that other class of persons who are sometimes called opticians, but for whom a more fitting name, I think, would be "spectacle merchants." They sometimes put in a good deal of time trying to fit glasses to patients when no glasses will improve vision. It is important to the practitioner that he may know when he has a case of this kind under consideration, so that, if necessary, he can refer the patient to some one who can do for the case what should be done. The subject is of importance to the general practitioner, that he may be able to recognize the cause of the trouble when he has a patient who gradually acquires a defect in vision, with very obscure symptoms, by making an examination of the urine, both chemical and microscopical, and thus save himself the possible humiliation of having an oculist make the diagnosis for him which he ought to make for himself. These cases are important to that other class, because there are some of them who, I have no doubt, would be very glad to send these patients to some one, especially after they have sold them as many pairs of glasses as they can get them to buy and still are unable to improve their vision. I have seen a number of cases under the care of opticians who had purchased glass after glass, and had been unable to see with them, and finally were compelled to consult some one who had discovered a lesion of the retina. The symptoms of this trouble come on gradually, and, as Dr. Nance has said, they are to be differentiated from those of uræmic amaurosis, and also from hemorrhages within the eye due to other causes. The two latter conditions come on suddenly, while the former comes on gradually.

Just a word or two with reference to ophthalmia neonatorum. It is estimated in Europe that ninety per cent of all of the total blindness is due to ophthalmia neonatorum. In the little experience which I have had in consultation work with this disease, I have found from careful observation that much of the trouble was due to the irritating medicines which physicians had been putting into the infants' eyes. I refer especially to bichloride. My own impression is that bichloride has no place in the

treatment of diseases of infancy, particularly as applied to the eyes.

**Willis O Nance**, of Chicago: I have been greatly interested in the paper of Dr. Clark. The results obtained in the cases cited are certainly gratifying, and should stimulate further employment of the remedy. These cases of dacryo-cystitis are among the most obstinate that the eye doctor has to treat, and if the zinc solution suggested can be depended on to bring about so rapid a cure in the average case as it has in the hands of Dr. Clark, it must be adopted as the remedy *par excellence*.

My experience with this class of cases, which has been considerable, has not been entirely satisfactory. There are always a certain number that are very intractable, and the surgeon cannot adopt a uniform method of management. The recent cases, as a rule, give little trouble, and promptly yield to conservative treatment. Again, however, we meet with instances where continued probing and syringing give little improvement. In these latter cases we are certainly justified in extirpating the sac.

As a lacrymal injection, after having used nearly everything from boric acid to silver nitrate, I get better results from ichthyol, in a twenty-five per cent solution, than any of the others.

The employment of electrolysis, I believe, offers some advantages, and I am now making some experiments with it upon a number of clinic patients, the results of which I hope to report at a future meeting of the society.

Dr. Firebaugh has called especial attention to the very great importance of early recognition of ophthalmia. This is certainly one of the chief essentials in its successful management. The clinical picture of the condition is usually so clear that it hardly seems possible that any intelligent medical attendant should mistake a diagnosis and allow the disease to go on untreated for any length of time. In Chicago, where a considerable proportion of the obstetrical work among those constituting the so-called lower stratum of society is done by midwives, we meet with frequent instances of frightful neglect. In my service at the Illinois Charitable Eye and Ear Infirmary I recently saw such a case, in which the baby's eyes were both destroyed before it was brought to the dispensary.

Another point which I consider of great importance, and one which I endeavored to make very emphatic in a paper on this subject, read before this society last year, is that ophthalmia neonatorum is a disease not necessarily of gonorrheal origin. The comprehension of this fact will make clear the necessity of employing Crede's, or some other, prophylactic measure as a routine method, instead of in only suspicious cases.

**Joseph B. De Lee**, of Chicago: I might ask to be excused for raising my voice in the presence of so many oculists, because I have had very little experience in the treatment of ophthalmia neonatorum, but in the prevention of it I have had a good deal of experience which,

I think, justifies me in taking a somewhat dogmatic position.

Every year about a thousand and seventy-five, or eleven hundred confinements pass under my personal care, more or less directly, that is, they are treated according to my own personal instruction, and that has been so for the last five years, and more or less so for three years previously, so I speak from an experience with seven thousand confinement cases. I have tried various methods of prevention of ophthalmia neonatorum. I finally, after going through the gamut, have come down to the present method which I take the liberty of presenting to you now. Formerly I used to see approximately two cases of ophthalmia neonatorum in six months. I have not seen a case under the new treatment for a year or more. One should try to prevent anything from getting into the eyes of the infant. The parturient tract should be kept as aseptic as possible during labor by means of douches, about the only time when I use douches. When the child's head is born, the physician should never wash anything from the eyes, because boracic acid is powerless to sterilize the secretion of the eyes. The baby's eyes are not washed with boracic acid. The nurse is instructed not to get anything into the baby's eyes during the bath or oiling. After the baby is dressed, a drop of nitrate of silver solution is instilled into the eyes, which is neutralized in about twenty seconds with salt solution. We have been carrying out that method of treatment in the last fourteen months with gratifying results.

**E. O. Sisson**, of Keokuk, Iowa (by invitation): I take great pleasure in being here and thank you for the invitation to say a few words on these papers. I agree thoroughly with what Dr. Andrews, of Chicago, has said. I feel that such papers as those of Dr. Nance and Dr. Firebaugh are particularly adapted to such societies as this. They contain words of wisdom for the general practitioner.

The subject of ophthalmia neonatorum is one that cannot be brought too often before the attention of the general practitioner. In a recent paper I prepared I went to the trouble to ascertain just what percentage of blindness is produced by ophthalmia neonatorum throughout the West. I wrote letters to the officials of the different blind asylums throughout the Mississippi Valley, and while I cannot give you the exact figures at this time, I may say that a very large percentage of blindness is produced by ophthalmia neonatorum.

In regard to the paper of Dr. Nance, I would like to discuss it at some length, but time does not permit. In such cases as he speaks of, the general practitioner should be impressed with the importance of the use of the ophthalmoscope in assisting him to arrive at a correct diagnosis, and if this were done a great point would be gained.

**Dr. Nance** (closing the discussion): In the preparation of my paper, I endeavored to make the subject-matter brief and concise. This has prevented the elaboration of certain points that might be well considered in connection with this subject. I cannot too strongly endorse

the remarks of Dr. Andrews, concerning the more general employment of the ophthalmoscope in cases presenting visual symptoms. The intimate relationship existing between ocular symptoms and many systemic disorders render such examination obligatory. The doctor's allusion to the "spectacle-merchant" is apt, and I would like to hear a more general discussion of the subject. I could enumerate a score of instances where patients have been "sold" glasses by members of this nomadic gentry, and have worn them for varying periods of time, blissfully ignorant of the presence of morbid intraocular changes which, had they been discovered earlier, would have prolonged the vision, and, in certain instances, the life of the patient for months and even years. The large number of these itinerant vendors of brass and glass met with throughout the State, and the apparent success with which they carry on their so-called calling, but tends to prove more conclusively the truth of the celebrated Barnum's oft-quoted remark on the ready gullibility of the American people.

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### CONGENITAL PHIMOSIS.\*

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#### A Protest Against Indiscriminate Operative Interference.

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BY C. C. HUNT, M. D., DIXON.

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The term phimosis is from a Greek word signifying "a muzzling, a closure." It is a term usually used to designate an elongated prepuce of the male associated with a narrow preputial orifice. Congenital phimosis means a phimosis that exists at or before birth. The normal prepuce of the male child at birth is somewhat elongated, reaches fully a half inch beyond the meatus of the urethra, the orifice is so small and is surrounded by such a quantity of white fibrous tissue that it cannot be retracted over the glans without undue force. The mucosa of the foreskin is, in the normal condition, adherent to that covering the glans. During the progress of growth and development of the child this narrow orifice gradually enlarges, the adherent mucosa of the foreskin gradually separates from that of the glans, so that at puberty, often a few years earlier, the foreskin may be easily retracted over the glans. Now and then, however, this natural separation and dilation do not take place; the preputial orifice remains

as at birth or is even contracted to a mere pinhole-opening; the primary adhesions within do not separate; the smegma is retained and its accumulation increases; local inflammatory processes set up and result in still further increasing the tenacity of the adhesions; the already small orifice is made smaller still by reason of connective tissue increase, a sort of hyperplasia of the foreskin at its distal end; the diameter of the preputial orifice having become much less than that of the urethra at its narrowest point the urine is not freely expelled; "ballooning" of the prepuce takes place during the act of micturition; the urine is not wholly discharged, the residual drops undergo chemical change and become irritant, so that the child becomes fretful, loses sleep, disorders of digestion ensue and a train of nervous disturbances follow as natural consequences. Not infrequently, especially under bad hygienic conditions, pathogenic micro-organisms gain entrance through the narrow orifice of the prepuce and light up a balanitis, specific or otherwise.

#### *Treatment.*

Of course the phimosis, whether natural or pathological, is effectually disposed of by the old Jewish rite of circumcision. But this sweeping measure however effective it may be far from satisfies the requirements of modern surgery. It is slovenly, and not by any means free from danger especially of a specific nature. Yet this ancient religious rite I am constrained to state has only too many imitators today among members of the medical profession. Seeing a case of narrow preputial opening associated with an elongated foreskin in an infant or child suffering or not from a reflex trouble of any kind or degree whatsoever, it is the too common practice among certain medical men, and medical women too, to immediately advise the operation of circumcision without reference to the age of the child and wholly regardless of the conditions present whether pathologic or otherwise.

Such practice, it is scarcely necessary to state should be condemned without reser-

\*Read at the 52d Annual Meeting.



vation. Various disorders of nutrition and neuroses innumerable have been attributed to congenital phimosis when the functions of the organ were unimpaired and no pathological condition present whatever. I am well convinced that the so-called reflex influences of a narrowed and elongated prepuce have been greatly exaggerated. I would advise operative interference, then, in congenital phimosis when the preputial orifice is or has become so narrowed as to materially interfere with urination and obstruct the outflow of the excretions, and naturally, too when the sequelae resulting therefrom warrants it. I would not advise circumcision of a redundant prepuce simply because of redundancy unless the redundancy is excessive, which is exceedingly rare.

As to the operation itself but little need be said. Keeping in view the essential objects to attain which any surgical interference is necessary, *any of the operations* recommended in our modern text-books will suffice. The object of this paper is not so much to advocate any special method *as to offer a protest against the indiscriminate amputation of or splitting up of foreskins that are normal and the functions of the organ in question unimpaired.*

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#### SOME ESSENTIAL POINTS REGARDING CHRONIC CONSTIPATION.\*

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BY J. W. HENSLEY, M. D., PEORIA.

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Chronic intestinal constipation has indeed a wide range as to cause—effects and curability. In our efforts to trace out some of the essential and most frequent causes of this most common—perhaps of all human complaints, a wide field is opened up for research at this day and age of the world. Then too the grounds to be traversed have been trodden in the main by writers and teachers from the earliest history of medical science down to the present day. It is therefore not my intention—so much to offer anything really new—but rather to impress what is already known to be true.

A good old brother has said the more he reads certain chapters of the Bible the more he finds in them. Another has said every time he repeats the Lord's prayer the greater becomes his impression as to the wisdom and eternal justice therein conveyed. So it has become a common saying that a good thing will bear repeating and repeating. The main purpose I have in view is to invite attention to the somewhat overlooked fact that an astonishingly comparatively great number of our adult population in towns and cities more especially are afflicted with chronic intestinal sluggishness of inertia due to atony of the gastro intestinal-secretory and muscular powers. It is to this form of constipation that I invite your attention. So long as I was engaged in the general practice of medicine to the exclusion of any especial line of work—like most of others busy always in treating the more acute forms of disease—it may be said with truth that I gave but little attention to the subject of chronic constipation of the bowels. In fact it may be truthfully asserted that in times not very remote in the past this trouble did not exist in the frequency and persistency that it does now. The busy practitioner has as a rule given but little attention to it—when existing as it were idiosyncratically—without other perceptible disease. Thus like asthma, rheumatism, hay fever and such it has become almost or quite proverbial that there is no absolute cure for either except by a change of climate or by the *vis medicatrix naturae*. Thus the sufferer is left to fall a victim to patent pills or other nostrums or else he falls within the unscrupulous mercies of the advertising charlatan—who at least relieves him for awhile—by this swelling the ranks of the quacks patients for a time and bringing discredit to the derelict—honest family practitioner. But is he honest when derelict of duty?

Since giving more direct and special attention to chronic gastric and intestinal diseases, I have really been surprised at the number of persons who go about, many of them apparently enjoying fairly good health, yet only having a passage from the bowels

\* Read at the 52d Annual Meeting, Quincy, May 20, 1902.

once in three, five, seven or ten days. A few I have found who went as long as two weeks. Nearly all of these only have an evacuation when active catharsis is resorted to. Since this causes gripings and much distress it is put off as long as possible, thus by degrees establishing progressive toleration. Some resort to rectal injections until the powers of normal expulsion are effectually lost. Others resort to patent pills or other nostrums, which is really safer for the time, but in the end adds fuel to the flame. The alimentary canal is the *prima via*, or the main passage way. Through this passage that which sustains life for any considerable length of time must go. Hence the importance of giving due attention to its various ramifications and functions both local and general. That the alimentary canal is a most favorable place for the propagation and abode of living things from the smallest microscopical animalcule up to the largest cestode cannot be gainsaid. Would one have believed that in certain forms of alvine putrefaction the discharges are  $\frac{1}{3}$  or even  $\frac{1}{2}$  microbes in bulk and weight? Yet such has been proven to be true not from theory either but by actual clinical facts. It is fortunate that but few of these tumbling, scrambling, devouring microscopical parasites can penetrate beyond a mucous membrane, and that the great bulk of them are but innocent bacteria, scavengers serving as sentinels and safeguards at vulnerable points. Tropical diarrhoeas and dysentery are as to cause mainly microbic. The effect if not death may be at first chronic, but the sequel is almost sure to be constipation, and the constipation from this source will be atonic, because a continued over-action finally results in loss of power. By far the greater number of persons afflicted with habitual atonic constipation are found in civil life and among the middle classes of adult people of civilized countries. The middle classes being composed of those who constitute the intellectual class—the professional class, the teacher, the pupil, those who conduct business on their own account and those who hold trusty positions in the business of others—are the principal ones most liable to

contract irregular action of the bowels. The reasons being mental strain, hurry and worry in business, sedentary habits, irregular hours, hasty and improper eating, neglect to attend the calls of nature, at first because of a lack of time, with unthoughted indifference, simply resorting to purgation for temporary relief at intervals with progressive resulting toleration. Often the intervals are extended for the sake of convenience. I cannot but believe that among the potent causes that contribute to the bringing about of this condition of the bowels lies in the food or ingesta of the present era. Dietary conditions are so much changed from what they were formerly that this per force of reason has to do with the increasing frequency of constipation. Corn bread is less used. Wheat bread has been changed to almost a pure starch food by the roller process of grinding which takes from it the gluten or nitrogenous part called the heart of the grain. Canned goods are not like the fresh products in either their nutrient qualities or stimulating properties. The processes of preparing and preserving many of these render them less adapted to the needs of the system. The sweets and chemicals used in their preservation alter their original properties. These alterations together with frequent partial decomposition, surely may and do cause disturbing conditions in the digestive functions. The food supply of the present age is so different to that of the past generations that we must at least become accustomed to the change before our rebellious alimentary growlings will accept the new situation.

Another important thing which must contribute to powerless action or expulsion at the time of defecation is position. The natural way as practiced by our fathers is changed to the more comfortable ways of the present day. In towns and cities more especially is this so. The ease of the modern closet must per force of position diminish expulsive efforts for by this the *vis a tergo* is greatly diminished. Before proceeding further I wish to qualify or refute *in toto* the assertion that constipation may exist without harm, either acute or chronic. It is unrea-

sonable to believe or conclude that decaying animal and vegetable matter can remain pent up in a temperature of 100 degrees for any considerable length of time, becoming putrid, and fed on by countless millions of microbes, without doing harm, whether at first obviously perceptible or not. By giving closer attention to those so afflicted one cannot escape observing the serious results that may and do follow in the train of what may be called sequelae. The dull heavy headache, the apathetic physical and mental manifestations, lack of appetite, coated tongue, foulness of breath and perspiration, defective digestion and assimilation, flatulency, hemorrhoids, torpidity of liver and kidneys, nervousness and insomnia, cardiac functional disturbances, catarrh of stomach and bowels, with women involving the uterus, are some of the results of chronic constipation as presenting pathologically and symptomatically. Then in pursuing this question let us consider the dangerous conditions that so often arise, and are increasing to an alarming extent. For instance typhlitis and appendicitis can be more reasonably attributed to constipation and resulting catarrh involving the cecum than perhaps to all else. Apoplexy results often from constipated bowels, acute or chronic. Paralysis is a reasonable sequel, and so on and so on. Speaking of the offensive breath of constipated people I am reminded of what General Miles said about the canned beef furnished our soldiers in Cuba, having an odor similar to disinfectants in an undertaker's establishment. The breath of a badly constipated person has an odor as of partially disinfected putrid animal substance, which can be told three or more feet away. It is so characteristic that if studied it becomes of diagnostic value. The agriculturist, the day laborer, or any one else used to outdoor labor, with plenty of physical exercise, and but little mental strain, having a vigorous appetite and eating the coarser nutrient foods, being seldom troubled with constipation, furnish something of an index as to cause, prevention and methods of cure when dealing with those of sedentary habits and an insufficiency of proper nutrients. A

defective or unsuitable food supply contributes largely to the costive habit. Disturbed digestion and defective assimilation are potent factors in the establishment and perpetuation of constipation. To correct these defects due attention must be given to appetite, ingesta, digestion and absorption. The digestive secretions in these cases are apt to be defective, both in quantity and quality. The gastric and intestinal mucous membrane is atonic and enfeebled. The muscular circular peristalsis is lost or reversed. Anaemia is but a part of a condition of which malassimilation and faulty metabolism are the essential features. If the bowels are to move there must be something to move. Foods furnishing a sufficiency of debris to stimulate secretions are needed. Both stomach and intestinal activity depend much on the demand and supply of the food. The demand must be coaxed, the supply furnished and the digestive processes restored to as nearly normal conditions as possible. Thus it becomes plain that gastric digestion together with intestinal digestion must be taken together in the management of persistent constipation. This opens a large field for observation and gives an extensive range for rational consideration. By this view we see that reasonable digestion and assimilation are prerequisites to normal action of the bowels. The greater number of those who suffer or tolerate habitual constipation from intestinal loss of power are victims of dyspepsia, whether this be the cause or the result. Then if there exists anorexia or a perverted appetite coincident with the constipation, we can scarcely expect to cure the one without due attention to the other. Were it more closely studied and heeded as to what part of digestion the various anatomical divisions of the alimentary tract has to do, defects could be better localized and corrected. By bearing in mind that the saliva is alkaline, the gastric secretions acid and the secretions emptied into the canal below the pylorus again alkaline, we shall be greatly aided in pursuing our studies regarding both diet and treatment. The defective powers and uneasy sensations of the stomach can



be rectified in many instances simply by measures which promote the regular and healthy evacuation of the bowels. The reverse is equally true. In all remedial attempts, the closer we keep within nature's physiological bounds the better shall we succeed. By knowing the varied processes of digestion, physiological and chemical, we are better enabled to supply nature's defects. Whether the fault lies in the processes of chimification or chyfication must be determined. The mixed contents of the small intestines furnish the natural stimulus of their peristaltic movements, while the excrements excite the larger bowels. Therefore there must be properly mixed contents on the one hand and a sufficiency of excrements on the other. Whatever has caused the weakened local or general powers should be remedied, if it still exists. If only remaining as a sequel, then we deal with the existing local or general conditions as presenting at the time of investigation. As to treatment there is no routine method to be pursued. To keep the bowels as nearly regular as possible while correcting digestive defects and other contributing causes or concomitants of the constipated habit is first of all necessary. Fix a time for going to the closet each day and educate both the patient and the bowels to respond to this. Soon after breakfast is the most convenient time as a general rule. The best way of doing this can only be determined by persistent trial. It largely depends on what's the matter or the cause and the idiosyncracies of each individual patient. First gain the confidence of the patient by promising a cure, provided he will only co-operate fully in the work. Impress upon him the dangers he is in as long as the constipation remains. Give him to understand before beginning his case that it may take six months or a year or more to effect favorable results. Direct him as to diet, exercise and other hygienic measures. I submit it, if this is not a preferable course, to that of ignoring the trouble as only trivial and unworthy of concern or consideration *per se*, being simply symptomatic of other defects. If we are to succeed whatever we may do should be

done in a positive way. The dangers of the situation should be impressed upon the patient. He is open to suggestion; let that fact serve as a warning against making light of his affliction. Avoid contradictory assertions, for such will weaken the auto suggestions which must be depended upon, both in holding the patient and in successfully managing his case. A record of essential points, both as to sayings and doings, will serve a much better purpose than by depending on memory alone. Besides this will strengthen the patient's confidence, by showing him that you are interested in his case. I insist on this point because of its importance, knowing as I do that in order to succeed mental or psychological influences must be brought to bear and maintained from the beginning to the end. When the natural stimulus is insufficient the want may be supplied by some substance which is involved in the food and accompanies it in its progress. Or more aptly at least for some time the defects may be supplied by appropriate medical treatment. After establishing these essential primary points the further treatment will require study and experimentation. Only one full and easy operation of bowels each day should be attempted, and that as already said at as nearly the same time of the day as possible. To secure this laxative medicines must be brought into the treatment from the very start. Such medicines as will produce the least griping by over-irritation or too free action should be selected. The combined aloin, belladonna, strychnia and cascara pill contains perhaps the best elements for this purpose, at least as I believe, now known in the whole scope of materia medica. The aloin excites peristalsis of the semi-dormant colon and rectum. The cascara of the *rhamnus purshiana* species excites intestinal glandular secretion and besides is a valuable hepatic tonic. Belladonna being anodyne, sedative and relaxant, modifies the excessive tendencies to contraction and griping, which would be distressing, from the action of aloin, cascara and strychnia, were these three left alone. The strychnia gives decided tone to the general system and the weakened muscular ac-

tion of the intestines. So the combination of these four remedies seems to meet the necessities of the case, in by far the greater number of those who are seeking to be cured of chronic intestinal constipation, in my experience at least. A pill composed of these four chemicals in a combination varying according to the requirements of each individual case, furnishes an anti-constipation remedy to me, or in my experience, the best of all. In order to meet the demands presenting at the beginning and throughout the progress of the treatment I have had compounded by the reliable firm of John Wyeth & Brother of Philadelphia, pills, chocolate coated, containing these four remedies in three strengths or formulae, which I am pleased to call No. 1, 2 and 3. No. 1 contains:

R

Aloin .....gr.  $\frac{1}{2}$   
 Ext. Belladonna.....gr.  $\frac{1}{8}$   
 Strychnia .....gr. 1.120  
 Ext. Cascara Sagrada.....gr.  $\frac{1}{2}$

No. 2 contains one-half of the aloin and cascara of No. 1, but retains the full quantity of belladonna and strychnia. No. 3 is composed of just  $\frac{1}{3}$  of all the ingredients of No. 1. These formulae of course can be changed to suit any one who may have by experience discovered a different combination as being superior. The strychnia needs to be increased to 1.60, 1.30, or 1.20 gr. with some. The dryness of mouth and throat produced by the belladonna may require a lessening of the quantity of this or a sufficiency of Jaborandi to modify this feature may be necessary in some cases. But with the three combinations at hand the changes that may be suggested can be supplied with other medicines being given during the day, which are nearly always required in the successful management of the constipation. These pills should always be given before the regular evening meal. Usually daily laxative medicines are given at bed time or before the time of retiring at night. This is wrong for two reasons. First, it requires 12 to 14 hours for such medicines to act. Second, before bed time or time of retiring at night is too indefinite with the

most of our town people. For this reason by taking the laxative before the regular time for the evening meal, which should be fixed at about 6 P. M., uniformity of action can the better be secured and maintained. This is an important point usually overlooked. I cannot dwell at length on treatment. Conditions presenting are so varied that to fix anything like a uniform treatment is out of the question. I only suggest the formula for a laxative as being always primary and continuous throughout the whole course of treatment whether the case be curable or not. I have selected this particular remedy because of its physiological action and because of its freedom from griping. Besides these it is a combination that differs from nearly all others, if not entirely all, by not as a rule, requiring an increased dose by continuance and toleration. Regarding local treatment, which requires very often massage, electricity, hydropathy and stomach and colon flushings, I may from experience say this. When intestinal catarrh exists, which is nearly always the case in atonic constipation, by first cleansing the colon, flushing with a 1,5000 to 1,10,000 solution of bichloride of mercury will serve an excellent purpose. By flushing with this solution once a week or 10 days for a few weeks or possibly longer, you will be astonished at the results both in the way of curing the catarrhal points and in lessening the intensity of the constipation. From one to two quarts of the solution at a temperature of 102 to 105 F. should be slowly run into the colon through a flexible tube reaching above the sigmoid flexure up towards or to the splenic flexion, the patient being in the knee chest position and retaining the solution as long as possible. This to some may seem a weak solution, especially so when the Academy of Medicine at Paris has adopted a 1,1000 acidulated bichloride solution for a post partem injection which the midwives throughout France are using as a vaginal and perineal antiseptic. The 1,1000 solution is too strong to be injected into the colon, besides it is not necessary. Earnest Laplace in Koch's laboratory together with

Koeh himself, have demonstrated that hydragryum chloridum corrosivum is the most powerful of antiseptics. And that even a 1:50,000 solution retains antiseptic powers sufficient to destroy the germs of suppuration and to disturb, weaken and destroy many of the most harmful germs existing throughout the prima via. When the catarrhal location is in the duodenum or common bile duct with constipation resulting, if olive oil be taken freely and continued for some time, good results will usually follow. There remains much more to be said upon the management of chronic intestinal constipation, but at this time I am limited. For instance free and continuous abdominal massage is almost indispensable. Electricity has never given more than temporary benefit for this in my experience, when used alone, though being of much benefit in some cases as a valuable adjuvant to other treatment.

Since concluding this paper a few days ago, Volume 1 of the Practical Medical Series of the Year Books, this one being written by Frank Billings, was received by me on subscription. In his article on Headaches he quotes H. T. Patrick's Classification of Headaches. It seems strange to me that while tracing the pathological conditions existing in the various types of headaches, constipation is not mentioned. In speaking of migraine he goes further and says it is neither caused by nor influenced by intestinal absorption, or words to this effect. Yet the daily, heavy dull headaches are most always concomitant with obstinate constipation. Besides there is scarcely a single one of the classified headaches mentioned that is not influenced more or less by confinement of intestinal debris, if not really produced by the toxemia or absorption of ptomaines, from the confinement of putrified alimentary substances, being fed upon by the more deadly microscopic animalcula. I cannot conceive of the idea of trying to prevent recurrent headaches, or of modifying the same during the explosion, without giving attention to the regular and free action of the bowels. Admitting that migraine usually begins in childhood or dur-

ing adolescence, and can very often be traced to heredity, being practically, so far as we now know, incurable, and limited only by advancing age, who will deny that even this will appear more frequently and with greater intensity if the bowels are obstinately constipated than if kept soluble and regular? I have seen migraine appear once a week or every ten days or two weeks right along, when constipation existed, which by giving more careful attention to the bowels, seeing that they act every day, the attacks come only once a month or at even longer intervals. Thus showing conclusively that the constipation or toxins from this, at least, aggravated the systemic conditions or metabolism, thereby causing the more frequent appearance of the hemicrania or megrim.

### SPINAL CORD CONDITIONS IN SEVERE ANAEMIAS.

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The purpose of this sketch is to call attention to a somewhat recently recognized condition of the nervous apparatus, particularly of the spinal cord, noticed or associated with anaemias of severe degree. Nutritional defects due to anaemia showing themselves in syncope, mental disturbance, insomnia, and even haemorrhages into the brain and retina as well as into the spinal cord, have been well established as clinical possibilities for a long period of time, but degenerative processes secondary to or associated with anaemias have been recognized only in very recent years. One of the first contributions to this subject was made by Nonne, who found degenerative conditions in the cord of ten out of seventeen cases of pernicious anaemia examined histologically, yet only two of these instances had symptoms referable to the cord during life. His observations have been abundantly confirmed.

While at first it was contended that these changes were largely confined to the posterior half of the cord, sparing the gray

\*Read at the 52d Annual Meeting of the Illinois State Medical Society.



matter, it was afterward asserted that the gray matter was equally likely to suffer.

Examination of a large number of reports will confirm to the unprejudiced investigator that the changes in the cord are in a sense mechanically located. That is, those portions of the cord which are less well supplied with blood are the first to suffer. Owing to the arrangement of the blood vessels supplying the anterior portions of the cord, especially the anterior horns of gray matter, this portion of a cross section shows comparatively few pathological changes in these cases, while the posterior half of the cord, embracing the sensory and the motor conducting tracts, being less vascular, supplied as it is by a number of small terminal arteries, in the lowered circulatory conditions of the anaemias, undergoes nutritional reduction and consequent retrograde changes, these show themselves in sclerotic conditions. In cases of long duration and extreme degree, the other portion of the cord, including the anterior horns of gray matter are involved with corresponding functional disturbance and physical signs.

That the anaemia is an active element in the causation of those cord changes is shown by the experiments of Massaro and others who have experimentally induced in animals extreme anaemia of the brain and cord attended by similar changes. The literature of the subject has been enriched by numerous contributions in Germany, England, and, notably, this country.

Many believe that in addition to the anaemia a toxic factor furnishes a very active element. The general view of the pernicious anaemias seems to be now in line with the supposition that it constitutes or is based upon a toxic state, and a toxic element which is competent to destroy the blood may also have some influence upon the central nervous system, although it does not seem necessary to invoke this factor in order to explain the changes which are there found.

It is now recognized that these changes occur not only in the classical pernicious anaemias, but in cachectic states of long duration attended by toxic factors. Sini-

lar changes, for instance, are encountered in the cachexia of cancer. It is also true that the majority of the individuals in these cases show a predisposition to lowered stability and perhaps a lowered structural strength of the nervous apparatus such as is indicated by a neurotic heredity.

Women are affected about three times as frequently as men, a proportion which accords with the incidence of the severe anaemias in relation to sex.

The symptoms of involvement of the cord are very commonly obscure and not infrequently entirely overlooked by the practitioner who is busied particularly with the cachectic state upon which they are engrafted. In other instances they attract attention early in the clinical history and receive major attention, commonly being mistaken for indications of locomotor ataxia, spastic paraplegia, or multiple neuritis. As the posterior half of the cord is involved the case may present clinically the indications of locomotor ataxia, but if the lateral portions of the posterior half of the cord, including the crossed pyramidal motor tracts, are principally or primarily affected, spasticity and rigidity with weakness may give rise to the supposition that the patient primarily has myelitis or an ataxic paraplegia. In the course of these cases one is likely to encounter fluctuations in the symptoms, so that a case which at one time is spastic with rigidities, cramps in the lower extremities, and increased reflexes, later on may present a flaccid paralytic state with abolished knee jerks and even lost control of the sphincters.

Almost invariably these patients complain in a major degree of disturbance of sensation; they describe numbness and tingling and formication, usually in the lower extremities, sometimes in all four extremities. Very commonly they describe their sensation in terms of pressure, either exerted from without or within. Some say the limbs feel as if swollen to bursting, others that the limbs feel as if compressed or as if bound with tight bandages or ropes. These are analagous to the complaints found

in postero-lateral sclerosis of whatever origin.

Owing to the paraesthesia, a suspicion of multiple neuritis is very commonly aroused in the medical mind, and the reduction of the reflexes which not uncommonly is present rather tends to confirm that suspicion. It has thus happened that several cases have come under observation in which a diagnosis of multiple neuritis had been made and the condition attributed to lead or alcohol.

Ordinarily the muscles do not waste more than would be explained by the cachectic condition of the patient and the general emaciation. Ordinarily, too, the muscles respond to the electrical stimulus in a normal manner, but in some cases in terminal stages, probably owing to the involvement of the gray matter of the cord in degenerative processes, distinct atrophies are added which may closely correspond to those found in progressive muscular atrophy of the spinal cord and the quantitative reduction of electrical stimulation attends this atrophy.

Owing to the malnutrition of the brain and perhaps in some instances owing to retrogressive changes in the cellular structure of that organ, disturbances of the mind are encountered. These patients are generally peevish, irritable, and forgetful, but what I look upon as more distinctive is the fact that they are commonly somnolent with a tendency, upon being roused, to exhibit a certain degree of mental confusion, particularly as to their surroundings, and may even at this time for a few minutes or few hours manifest a little delirium of a low, quiet type. Practically it is a continuance of the dream state which they cannot shake off upon being aroused, and usually subsides spontaneously or upon further stimulation. When this is well marked, usually there is a loss of perception of time, so that a patient is not reliable in regard to current events.

On the part of the optic nerve, not infrequently retrogressive changes are to be observed constituting greater or less degrees of atrophy. A diminution of vision and the reduction of the visual field, due to the

anaemic state, is the rule. Neuralgias are also common.

The duration of the disorder is dependent upon the associated anaemia. One may say that the cases have a tendency to last from one to five years after presenting clinical symptoms of the involvement of the nervous apparatus, and the prognosis is dependent entirely upon the condition of the blood. Most of these patients sooner or later perish miserably. They progressively become more and more helpless, finally are confined to bed, and involvement of the sphincters and bedsores may render them abject sufferers. The paralytic condition has a tendency to encroach in an ascending manner upon the nervous apparatus, so that they present a chronic ascending spinal paralysis. Paraesthesia followed by anaesthesia gradually creeps up the trunk, advances also along the upper extremities, and finally involves the entire body. The nose, tongue, and lips are sometimes similarly affected, and eventually the patient perishes, commonly from involvement of the respiratory or cardiac apparatus. The pharynx may be involved, so that swallowing becomes difficult, aspiration pneumonia is likely to occur, and death from inanition or suffocation is a possibility.

In the treatment of these cases attention is fixed upon the cachectic state or the anaemia. Without attempting to cover the whole field, it may be stated that a great deal may be done even in the most pronounced cases of pernicious anaemia by continuous efforts to render the intestinal canal septic, and to add to the quantity and if possible the quality of circulating blood. For this purpose intestinal injections of normal salt solution, as often as every two hours in some cases, have been attended by prompt and more or less persistent improvement in the general state, without, however, in my own experience, being followed by any betterment of the blood. I have to remark in this connection that my friend, E. F. Wells, has verbally communicated to me the notes of one case in which a patient has apparently recovered under a similar course of management from a well marked pernicious anaemia, in-

dictated by all the classical blood signs, and has remained in a practical state of health for two years. Haematogenic drugs and intestinal antiseptics with careful dietetics and general supportive measures must be judiciously employed.

The frequency of these conditions and the tendency to their misapprehension have been enforced upon my attention during the past year by coming in contact with six cases, brief notes of which I append. To these I might from my case books add a dozen more.

CASE I. Mrs. D., Rock Island, Ill., married; fifty-eight years of age. Has always been an unusually strong woman and particularly free from serious illnesses. She is the mother of a family of grown healthy children. For the past two years she has been in failing health, and recently has had a number of synepal attacks which led physicians whom she consulted in the East to consider her heart at fault. The weakness grew progressively greater until the time I saw her, September 26, 1901, when she was unable to stand. She complained of numbness in all four extremities, the numbness extending as high as the umbilicus in front. Its upper margin was indefinite, and upon examination the disturbance was found to be a hyperaesthesia. All reflexes in the lower extremities were greatly reduced and the knee jerks were practically abolished. The patient was well nourished, but presented a slight yellow hue which at times was stated to be more intense.

Examination of the blood, made by Dr. Evans, of the Columbus Medical Laboratory, showed haemoglobin, 45 per cent, red cells 2,648,000, haemoglobin cellular index, 83, white cells 4,500. There was distinct poikilocytosis, with unusual variation in the size of the red cells, and in their reaction to stains, and nucleated cells were present. Dr. Evans unhesitatingly pronounced the blood to be that of primary anaemia.

From the physical condition and the nervous symptoms, taken in conjunction with the pallor and appearance of the patient a diagnosis of pernicious anaemia was

made. She returned home and after fluctuating for better and worse died in January, 1902.

CASE II. Mrs. W., a married woman of sixty-two, with a grown family of healthy children. No personal or family history of any significance. For the last three years she has been in lowered physical health and was considered hysterical and neurasthenic, receiving one course of rest treatment for alleged neurasthenia. She spent the summer of 1901 in the east, returning to Chicago in November. She had consulted some of the leading physicians in New York. Dr. Dana made a diagnosis of ataxic paraplegia. He had the blood carefully examined and considered the anaemic state, which was markedly present, of a secondary variety, and put the patient on large doses of iron, raw beef, etc.

November 2, 1901, the patient was seen at the request of her physician, E. J. Doering, and was found vomiting everything taken into the stomach. She presented an appearance of good nutrition, but seemed very feeble and extremely anaemic. The tongue was raw and red and she stated that for years she had had a red tongue. Power in the lower extremities was greatly reduced; she was able to move them at the hips, but not at the knees or below. There was sphincter incontinence both of bladder and rectum, and also numbness in the lower extremities which amounted to anaesthesia from the knees down, reduced sensation to the groins, and paraesthesia to the lower end of the sternum. The upper extremities were numb from fingers to mid-arm. All reflexes were increased, and the lower extremities were in a state of spastic rigid extension with a tendency to cross leg. Ankle clonus and the Babinski reflex were easily elicited.

Examination of the blood made at this time by Dr. Evans, of the Columbus Laboratory, showed haemoglobin 57 per cent, red cells 2,416,000, corpuscular index 117, white cells 5,800. A few normoblasts were found. The red cells showed some poikilocytosis with irregularity in size. Dr. Evans stated that the case was in all proba-



bility pernicious anaemia, or at least a borderland case.

The patient was fed by the rectum and the stomach allowed to recover from the forced feeding. Iron and arsenic in large doses were employed. She made considerable improvement and the blood state improved to some extent, but early in this year she commenced to run down rapidly, and was mentally very vague, often in a delirious or dreamy state with prolonged somnolence, and the case seemed to be terminating fatally. At this time she was put upon rectal injections of normal salt solution every two hours, and oxygen was employed for fifteen minutes every hour. Within forty-eight hours her condition had notably improved, the delirium, somnolence and mental vagaries entirely disappeared, her appetite picked up, she made a marvelous change for the better, but the blood remained practically as before. The betterment continued under less frequent administrations of salt solution, but a bed sore developed over the sacrum and from it septic absorption resulted in a number of puffs of fever which had a tendency to reduce the patient's strength. The nutrition, however, remained fairly good. Through it all the tendency to paralysis increased; the spasticity disappeared and was followed by complete relaxation of the lower extremities. The upper extremities became slightly spastic and rigid and have so remained. The numbness gradually involved the entire body and at present only the face is exempt. Distinct muscular atrophy has now appeared in legs and hands, with reduced quantitative electrical reactions. The contours are those of a progressive spinal muscular atrophy.

Analysis of the blood made April 30th by R. H. Harvey shows haemoglobin reduced to 25 per cent, the red cells number but 600,000, while the color index of the cells is 200. The fibrin network, which has been reduced throughout in this case, is now entirely absent. There is no tendency of the red cells to congregate in rolls, the red cells are often irregular, large and vacuolated. There is extreme poikilocyto-

sis, and a few normoblasts and megablasts are to be observed.

The physical state is one that precludes the expectation of prolonging life beyond a few weeks.

CASE III. Mr. K., from Hancock, Wis. Seen April 5, 1902, and subsequently placed in Wesley Hospital. He is an unmarried man of twenty-six, and has been entirely free from physical illness and all venereal infection. He was industrious, hard-working, and abstemious. He reports that he was considerably run down in 1901. Since January, 1902, has noticed weakness, pains, and cramps in his legs. Is now greatly constipated. There is some uncertainty in the control of his bladder; a girdle sensation around the lower portion of the belly; staggering when on his feet, especially with closed eyes, as when washing his face; and numbness of the legs extending to the lower portion of the trunk as high as the navel. He was sent to me with a diagnosis of tabes.

Upon examination, I find him well nourished, but very pale and anaemic. There is pronounced constipation, with a tendency to prolapse of the rectum when the bowels move. There are anaemic murmurs at the base of the heart, propagated into the neck; the general strength and energy are greatly reduced. He is very uncertain upon his legs, walks with a heavy, staggering, ataxic gait, and his lower extremities are very weak. The reflexes are all increased. Partial clonus is obtainable at each ankle and the toe sign of Babinski is present. The upper extremities are free from paraesthesia and motor disability.

Examination of the blood, made by Professor Zeit, shows 60 per cent of haemoglobin, with 2,400,000 reds, presenting a color index of 1.24, white cells number 22,000. no nucleated reds are present. In the opinion of Dr. Zeit, it is one of the borderland cases with strong indications toward the pernicious form of anaemia.

The patient is receiving rectal injections of normal salt solution, a pint three times daily; Bland's iron, 20 grains, three times daily; careful feeding. In the short time he has been under observation he has ap-

parently made some general improvement, although the blood changes are immaterial.

CASE IV. Mr. R., aged forty-five. Family history negative. He is a married man and has two small children. Had a chancre eighteen years ago, but no history of secondaries; has had gonorrhoea many times. His present illness began somewhat suddenly on the evening of January 6th, when he was taken with vomiting followed by diarrhoea. He was made very weak and the weakness persisted, compelling him to remain in bed three weeks. He then managed to work a week, but the diarrhoea again became pronounced and he was compelled to stop work and has been unable to attend to any business since. For over a year he has noted a peculiar tingling sensation in his legs, extending nearly to the knees, and since his present illness began this has become worse. \*It is always present and has extended to the body and involves the hands. There is also a band of constriction across the centre of the abdomen about six inches wide. He is dizzy, especially upon arising from a recumbent posture. The appetite has been ordinarily good.

He was admitted to Wesley Hospital on March 7th, on the surgical side, on the supposition that there might be a surgical lesion of the intestinal canal, but later was referred to the medical side, under the care of Dr. Webster, upon whose suggestion I saw him on April 8th. At that time he presented the appearance of a fairly nourished man, but was blanched, with slight yellowish discoloration on the chest and extremities. It was found that he was slightly uncertain upon his feet irrespective of his dizziness, and all his reflexes were reduced. There was ataxia in all four extremities, but there were no eye signs of tabes.

Examination of the blood showed 2,300,000 reds, presenting a color index of 1. There was marked poikilocytosis, with great variation in the size of the red cells. The leucocytes numbered 20,000, haemoglobin, 60 per cent, decrease in the fibrin network. This was considered an instance of a borderland blood state pointing toward pernicious anaemia. The patient was put upon rectal injections of normal salt solution,

Blaud's iron, red meat in his diet, and this has been continued since, with general improvement as to his physical feeling and ability, but no improvement in the condition of the blood.

CASE V. Mr. B., single, bookkeeper, fifty years of age. Was admitted to St. Luke's Hospital, under the care of Dr. Favill, on March 9th. He complained of numbness in his hands and the lower extremities, reaching as high as the waist line. There was a feeling of puffiness or distention in the lower portion of the abdomen and in the region of the bladder, and there was pain in this region. The calves of the legs felt to the patient swollen beyond the capacity of the integument, although they presented no appearance of oedema. There was difficulty in moving the bowels, although the movements were soft and he complained of having intestinal diarrhoeas for many years. He began to lose weight about the first of January this year and has lost about 30 pounds. He presented an emaciated, anaemic, cachectic condition with a distinct yellow coloration of the skin. He dates the present illness back to May, 1901, when after a hard day's work he was completely played out and never has been able to recover any degree of strength. The patient has had a number of minor illnesses, including malaria, pleurisy, and chicken-pox, but denies venereal infection. There is nothing in his family history that is notable in this connection.

When I saw the patient, at the request of Dr. Favill, the above-mentioned points were confirmed and it had also been discovered by the resident house physician that the stools contained the ova of what appeared to be the short variety of tapeworm. All efforts to dislodge the parasite, however, have failed, but the stools are now free from such ova. Reflexes in the lower extremities were absent. The man was uncertain on his legs, but static ataxia was comparatively slight. The numbness had a tendency to fluctuate, rising and falling in the body levels, also extending higher at times in the arms. When seen, it embraced merely the fingers and the legs.

Examination of the blood showed a most marked condition of pernicious anaemia, the white cells numbered 7,200, the red cells 1,264,000, haemoglobin, 36 per cent. Poikilocytosis was extremely marked. Microcytes and macrocytes were numerous, nucleated red cells were also present. The condition of the blood varied but little during the remainder of the patient's hospital residence. At times he was better, at times worse, and on the whole his condition was not materially changed. During the administration of anthelmintics and cathartics the anaemic condition was made worse. He left the hospital unimproved about May 1.

CASE VI. Mr. L., a blacksmith of fifty-four, of perfectly good personal and past family history, the father of a healthy grown family, never had had any serious illness. When I saw the patient at his home in the northwestern section of Chicago, he presented an appearance of great weakness. He was fairly well nourished, but decidedly pallid, and his skin was icteric. It was with great difficulty that he was able to get out of a chair or maintain himself upon his legs. He stated that he had been in failing health since last November, when he had what was supposed to have been the grippe, from which he made a fair recovery, but was not able to do hard work thereafter. About the holidays he experienced a tingling in all four extremities, and the physician he consulted considered that he was suffering from multiple neuritis and attributed it to lead or brass, although he did not work in those metals. He had steadily grown worse.

I found upon examination that the numbness in the extremities reached as high as the waist line, where there was a distinct band of hyperaesthesia, and the numbness instead of being anaesthetic was hyperaesthetic throughout. The "girdle sensation" at the upper level was clearly described by the patient. The upper extremities showed the same tingling or numbness, extending nearly to the elbows. The reflexes were reduced and the knee jerk was obtained only with very great care and by reinforcement. He complained that the legs felt as

if they were in bands or in a vise or wrapped with cords, but his major complaint was his great weakness.

He was transferred to St. Luke's Hospital on March 10, 1902, a tentative diagnosis of pernicious anaemia having been made largely based upon the nervous symptoms. It was found that the haemoglobin was 35 per cent, red cells 1,976,000, showing marked poikilocytosis, irregularity in size, irregularity in staining qualities. The whites numbered 5,400. There were no nucleated reds. The fibrin network was decidedly reduced. This condition of the blood continued during the three weeks he was in the hospital, and during that time he received normal salt solutions by the rectum, iron and red meat, massage, and other general measures.

Owing to the impossibility of giving a favorable prognosis, he was removed to his home about April 10, 1902, and died on April 22d.

### New Incorporations.

The following corporations have been licensed by the Secretary of State at Springfield:

The Chicago Correspondence School of Nursing, located at Pierre, S. D., with a capital of \$5,000, is licensed to transact business in Illinois with a state capital of \$2,500.

The Dr. Pratt Laboratories, Chicago; capital, \$100,000; manufacturing toilet and medicinal preparations; incorporators, Arthur W. McGowney, Eli Moses, and Johan Waage.

The Charles A. Carver Company, Chicago; capital, \$10,000; teaching physical culture; incorporators, Charles A. Carver, Henry A. Mix, and Harriet B. Carver.

The Tarkino Red Cross Company, Chicago; capital, \$5,000; manufacturing proprietary medicines and remedies; incorporators, J. H. B. Howell, M. A. Long, and William A. Barnes.

Prof. Lorenz, at a banquet tendered him by New York bankers, said, among other things:

"I have had some curious experience in this country. Perhaps the most curious was in Chicago. The board of health there made me undergo an examination in medicine, although I think I know something of my branch of my profession. Curiously enough, some weeks later they made me a doctor of laws, though I know nothing of law.

"Taught by that experience I shall not talk more to you, because I fear if I stay here longer you will make me a banker, because I know nothing of banking."



# The Illinois Medical Journal.

The Official Organ of the State Medical Society.

EDITOR—George N. Kreider, A. M., M. D., Springfield.

Official Reporters of Affiliated Societies—

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All communications should be addressed to the Editor, 522 Capitol Ave., Springfield, Illinois.

The Society does not assume responsibility for any statements or opinions published in the JOURNAL.

The JOURNAL is published monthly. The subscription price is \$3.00 per annum in advance. The JOURNAL is furnished free to the members of the Society.

## FEBRUARY 1903.

### MEDICAL LEGISLATION IN ILLINOIS.

All legislation like education is a matter of growth. This is particularly true in our new and progressive country where one condition of society is hardly provided for before a new and entirely different condition arises requiring an amendment or an entirely new law. This has been notably true regarding laws regulating the practice of medicine in Illinois. The first law was en-

acted in 1811 and the Board quickly assumed a high position giving Illinois first place among all the states. But as early as 1883 we find that a movement was started to take the examining power away from the Board of Health and vest it in a Board of Examiners which should have as its only duty the regulation of the practice of medicine. In 1887 the original law was supplanted by another statute which was an improvement

and in 1899 still another law was enacted. Many of the aspirations of the profession were contained in these laws but still they have been found far from ideal. This is not remarkable. These attempts were necessary to educate the people and the profession.

\* \* \* \* \*

Believing that the citizens of the State desired an ideal law the State Society again appointed a committee at the Springfield meeting with full power to go to the bottom of this subject. This the committee has carefully done by repeatedly addressing first every medical man, and every medical society in the State and secondly by asking advice from the executive officers of every other state having such a law on its books. In this work over 30,000 letters have been written. A league of over 1,000 physicians has been formed each member of which has contributed money to assist in the enactment of the law. These physicians embrace representatives of all schools. Forty societies of the State have considered and endorsed the work of the Committee. The bill has been drafted by leading attorneys.

\* \* \* \* \*

The bill as finally drafted contains a section providing for the examination and licensing of nurses. This is not only placing that duty in the hands of those competent to properly handle the matter, but it obviates the necessity of the organization of another Board.

\* \* \* \* \*

Every detail for success has apparently been looked after. Members of the legislature have been pledged to its support in sufficient numbers to insure its passage if they are called upon. Now the only command necessary for the profession is a forward march. This the committee will give in the near future and we prophesy that

Illinois will soon have the best law on this subject to be found in America. If our readers are called upon by the Committee to engage in active work we hope they will give accurate and immediate attention to the request.

#### MEDICAL JOURNAL ITEMS.

As will be seen by a reference to our Correspondence Columns, the Peoria Medical Journal after a long and honorable existence has ceased publication. Its editor, a brilliant and forceful writer, has recognized the importance of concentration of the efforts of the profession on one journal which should be the representative of the State Society. The Journal of the Morgan County Medical Society has also been abandoned. The passing of the journals marks a distinct advancement in the history of professional organization in Illinois. The progress of the past three years has been a surprise even to those in the best position to observe it.

\* \* \* \* \*

Three of our talented members are conducting journals for other states. C. W. Lillie of E. St. Louis, is editor of the Clinique and F. P. Norbury of Jacksonville, is editor of the Fortnightly both published in St. Louis. Harold N. Moyer of Chicago, is the editor of Medicine, a highclass Detroit publication. Medicine has been increased in size and made more attractive by the able editorials of Moyer. He says: "Our aim is to publish a journal for the physician who has prepared himself in a serious and painstaking manner—the man who is doing the everyday work of medical practice, and who aims to do it in a competent and intelligent way and looks to his journal for help. We shall not publish a journal for the laboratory worker, nor on the other hand shall we try to fill its pages with ready made formulae." All these aims are admirably filled by Medicine.

\* \* \* \* \*

The Chicago Medical Recorder has celebrated the new year by coming out in an enlarged and improved form. Nearly eighty pages of advertisements indicate its value

as a medium for reaching the profession of Chicago.

\* \* \* \* \*

The Medical Review of Lincoln, which comes near being the official organ of the Nebraska State Medical Society, has found it necessary to advance its subscription price to two dollars, doubtless because of the increased cost of paper and labor. This excellent journal contains only about one-third as much reading matter as the Illinois Medical Journal.

\* \* \* \* \*

The Iowa Medical Journal, Des Moines, which is also nearly the official organ of the Iowa State Society, devotes its January issue to a directory of the physicians of Iowa; 3473 names are listed which comes within 250 of the number given that State by the census bureau in the numeration of 1900. We call the attention of the officers of the A. M. A. to this fact as some of them are inclined to the belief that the number of practitioners given by the census authorities for the entire country 132,225 is entirely too high. This claim is not borne out by the statistics given by the Iowa Journal. Of this number less than 800 are connected with the Iowa State Society.

\* \* \* \* \*

The Interstate Medical Journal of St. Louis, monthly, subscription price \$2.00, devotes its entire 78 page January issue to a review of the medical literature of the past year. The excellent review of surgery is written by Willard Bartlett son of our esteemed life member, Aurelius T. Bartlett of Virden.

#### RECURRENCES IN TUBERCULOSIS OF THE JOINTS.

The periods during which hospitals have existed in our large cities are becoming sufficient for the gathering of clinical data of great value; this is especially true of many institutions of eastern cities. An addition, especially valuable from the point of view of prognosis, to the subject of tuberculosis of the joints and its treatment by orthopedic or more radical measures has been made

recently by Painter (1.) from the orthopedic clinic of the Carney Hospital of Boston. The brief *résumé* of cases of tuberculosis of various joints characterized by an exacerbation after a number of years of quiescence or of apparent cure, has many features of great interest.

Painter was so strongly impressed with the liability of the disease to recur that the article is entitled "The Malignancy of Joint Tuberculosis." The average number of years in 47 cases, intervening between the termination of the first attack and its recrudescence was 12½ years. This is several years longer than the average periods of observation of cases reported as cured in many of the text-books treating this subject. As a rule the return of the disease took place at its former location. In 4 of the 47, tuberculosis of other parts of the body occurred by metastasis from the diseased joint. This small number of instances of generalization of the disease is in striking contrast to the prevalent ideas of such an eventuality. It was ascertained that traumatism was associated with the relapse in numerous cases. An ankylosed limb with perhaps a marked deformity offers exceptional opportunities for the transmission of force to the granulation tissue formed around foci of tuberculosis in process of encapsulation and healing; even slight jars and trivial accidents that would escape notice in healthy individuals may cause damage to diseased joints of this nature, adequate to initiate a severe attack of the former trouble. Relapses during adult life deserve a prognosis less favorable than cases of joint tuberculosis manifested for the first time during years of maturity. When the disease appears late in life, recovery is less likely than among children. The large percentage of cases in which a second attack was experienced after many years indicates the need of a more careful consideration of the methods of treatment commonly employed in such affections in childhood and the youthful periods.

Such contributions as this marked by a

(1.) Boston Medical and Surgical Journal 1903, CXLVIII, 29.



conservatism requiring many years to estimate the efficacy or inutility of therapeutic surgical measures is in full accord with a spirit of reaction evident in many quarters. There is a notable industry in tracing the subsequent history of patients to determine the benefit derived from certain operations, a willingness to attach full importance to unfavorable terminations and a disposition to abandon some operations on account of their great mortality or slight benefit.

#### INGRATITUDE OF THE LAY PRESS.

For months several of the leading Chicago dailies gave space to the advertisements of one Dr. J. M. Peebles who styled himself "the grand old man of Battle Creek, Mich., who cures so-called incurable or hopeless cases free through the wonders of psychic science." These papers aided Peebles in his scheme to extract coin from numberless defectives, but when the postal authorities took up the task of stopping the generous philanthropist, not a single paper came to the defense of their patron. They all printed the following dispatch from Detroit, which is evidently calculated to injure his business:

Detroit, Mich., Dec. 22, 1902—Doctors James M. Peebles, Walter T. Robo and Charles M. Green, of the People's Institute of Health, Battle Creek, Mich., were convicted by a jury in the United States district court here of violating the postal laws. A thirty day stay of proceedings will prevent immediate sentence.

It was charged that advertisements of their mental "cure" by mail for all sorts of ills, constituted an attempt to obtain money by fraud.

During the trial Dr. Robo testified that he believed Dr. Peebles had a healing power like that of Jesus, only that the doctor's power was small.

Dr. Robo admitted that if a patient at a distance managed to procure Dr. Peebles' signed instructions and followed them faithfully, the cure would not be effective if the patient had not paid the fee of \$1. It is said the People's institute had been doing a flourishing business.

#### MORTALITY STATISTICS OF ILLINOIS CITIES.

Under this head we propose to assemble the statistics from as many cities in the State as maintain health officers and are willing to send us their reports. Readers of the Journal who are connected with the health departments in the various cities will

confer a favor by using their influence to have these reports sent us regularly. This month we submit the reports for December from:

	Popu- lation.	Death Rate.	Diph- theria.	Scarlet Fever.	Measles.	Small- pox.	Typhoid Fever.
Chicago.....	1,820,000	16.38	76	23	15	0	122
Springfield..	36,000	13.74	2	0	0	0	1
Jacksonville..	16,000	12.12	0	0	0	0	1
Freeport.....	13,258	9.00	0	0	0	0	0

Springfield issues a monthly bulletin of vital statistics. Mr. Frank Patterson informs us that he would be pleased to exchange bulletins with other cities in Illinois.

Chicago issues a weekly bulletin of four pages containing besides the vital statistics much collateral information of great value. Commissioner Reynolds advocates portable hospital pavilions for the control of contagious diseases. With these diphtheria which alone lost nearly 600 lives during the year 1902, may be as successfully handled as smallpox of which latter disease there have been but four deaths during the year. Diphtheria, since the introduction of antitoxin treatment, is every whit as controllable as smallpox and its control requires practically the same measures—prompt isolation of every case, immunization of all "contacts," disinfection of premises—the first essential of which is suitable hospital provision.

Chief Medical Inspector Spaulding declares in the most emphatic manner that there is absolutely no insusceptibility to vaccination. The experiments made by the department would indicate that lemon juice is of value in destroying the germ of typhoid fever.

J. F. Dicus, President of the Board of Health of Streator, makes the following monthly and annual report:

There have been 160 deaths in the city since January 1, 1902. Sixteen of these occurred during the month of December. Three of these deaths by accident, five by pneumonia, four from bronchitis, one from typhoid fever, one from tuberculosis one from heart failure and one from apoplexy. Five of the sixteen deaths were from respiratory troubles.

We have seven cases of typhoid fever in the city at the present time, every case being

imported. One came from Cicero, Ind., three from Chicago and three from Aurora, Ill.

We have no contagious disease in our midst, and no infectious disease except the seven imported cases of typhoid fever referred to above.

This, we think, speaks well for the general sanitary condition of our city.

Our death rate has been very low for the year.

C. G. Muehlmann, Health Commissioner of Pekin, reports 7 deaths for December and pneumonia the prevailing disease.

## Correspondence.

### PEORIA MEDICAL JOURNAL DISCONTINUED.

To the Editor:—

Allow us to announce through your columns the discontinuance of The Peoria Medical Journal, with which we have for many years been connected. The growing tendency to organization and concentration of professional interests seems to lessen the need of independent provincial publications, and point to the desirability of centralizing professional literary effort. To that end, while thanking our former contributors and patrons in this State for their favors, we recommend to them the desirability of centering effort on their own publication, The Illinois Medical Journal, with the zeal with which they have heretofore assisted us in sustaining ours.

Faternally yours,

O. B. Will.

Peoria, Jan. 12, 1903.

### THE ENNO SANDER PRIZE ESSAY.

Dear Sir—Will you kindly announce in your journal that the Enno Sander Prize, of the Association of Military Surgeons of the United States for 1903 will be awarded to the author of the best essay on

The Differential Diagnosis of Typhoid Fever in its Earliest Stages.

The board of award will consist of,

Dr. Austin Flint of New York,

Colonel Calvin DeWitt of the Army,

Prof. Victor C. Vaughan of Ann Arbor.

Full information concerning the contest may be obtained from Major James Evelyn

Pilcher, Carlisle, Pa., the Secretary of the Association.

Thanking you in advance for the courtesy, I remain,

Very sincerely yours,

James Evelyn Pilcher.

Carlisle, Pa., Jan. 10, 1903.

## OBITUARY.

Margaret Taylor Shutt, M. D.

Died in Springfield, Saturday, Jan. 24, 1903, Dr. Margaret Taylor Shutt, daughter of the Hon. Wm. E. and Mrs. Shutt, aged 35 years. Dr. Shutt was a woman of more than ordinary ability. She was possessed of a happy disposition and a strong character which insured her the love and respect of all those with whom she was brought in contact. Her oratorical ability as shown at the banquet of the State Society at its last meeting was of a high order. Dr. Shutt began her public career by taking up the study of the law. She was granted a license to practice by the Supreme Court passing the examination with a high grade. Feeling that the medical profession offered a better opportunity for her life work she took up the study and graduated from Cornell University, New York City, in 1900. She was probably the only woman who has ever received degrees in both the legal and medical professions. She began the practice in her home city where she soon was surrounded by a large clientele. She was appointed pathologist to St. John's Hospital and labored diligently and efficiently in the laboratory of that institution.

She continued her studies each year in the East. It was probably while laboring among the poor of Brooklyn, during the summer of 1901 that she contracted intestinal disease which was ultimately the cause of her death. The Sangamon County Medical Society attended the funeral services in a body together with a multitude of friends from every walk in life. The staff of St. John's Hospital at a meeting adopted the following resolutions:

Whereas, It has pleased the all-wise Father to call from her earthly labors our beloved friend and colleague Dr. Margaret Taylor Shutt therefore

Resolved, That we the members of the staff of St. John's Hospital with whom Dr. Shutt has been associated for the past two years, desire to put on record our appreciation of her character and attainments.

Dr. Shutt was a woman of high ideals, great industry and devoted to her profession. She established the department of pathology in this hospital and gave freely of her time, money and strength to this difficult and tedious work. No investigation was too arduous for her, and her enthusiasm, intelligence and helpfulness in suggesting further means of research in a difficult case made her beloved by the whole staff.

Her devotion to those patients coming under her care was complete. She had prepared herself for the healing art by a long course of study and she constantly kept herself posted on current literature to broaden her knowledge. She frequently made trips to the Eastern hospitals and labored among the poor of Brooklyn and New York to enable her to become proficient in her chosen specialty. While she has been taken from us early in her career she has left us a noble example which will bear fruit in stimulating all physicians who had the privilege of her friendship to honest and unselfish efforts in the care of the sick and suffering.

#### George W. Fringer, M. D.

At noon on Monday, Dec. 17, 1902, passed from this life Dr. George W. Fringer of Pana, Illinois.

Dr. Fringer was born in Taneytown, Maryland, March 24, 1834. He grew to manhood in that state, and in February, 1862, was married to Miss Martha V. Cover, of Gettysburg, Pa., and immediately thereafter removed to Shelbyville, Illinois. That same year he enlisted in the army of the war for the Union, and remained on duty until discharged because of illness (which lasted several months,) when he entered the drug business in Shelbyville. In 1866, he disposed of his business in Shelbyville and removed to Tower Hill.

In 1869 Dr. Fringer was graduated in medicine from the Missouri Medical College. He gained a large practice at Tower Hill, where he remained until he removed to Pana in 1889.

Dr. Fringer was devoted to his profession, and inclined to consider with becoming judgment and faith the modern theories of medicine and surgery up to the few months prior to his last illness. He was much disposed toward medical organizations, and while he did not write or talk much what he said was always to the point. He was a member of his local and district as well as State and National Societies, and took a deep interest in their welfare. He was at one time president of the District Society of Central Illinois.

Probably no man was more highly thought of in the community in which he resided, and the many expressions of esteem that have come to the writer from both profession and laity testify to the high regard in which he was held. He was prominent in the affairs of his community, and having retained the gentlemanly bearing, courteous manner and hospitable characteristics of his native State, he always commanded the respect and attention of his fellows. As one of his neighbors expresses it, he was always the same "genial, sincere, outspoken, candid friend. He was a hater of shams, and too honest hearted to call a spade by any other name."

As a physician, Dr. Fringer pursued a straight forward course, his patients being able to rely upon his statements as the expression of his honest sentiments. Hence they were his most loyal friends. This trait of hatred for sham was a marked characteristic of the man,

and he was consequently placed in many positions of trust. Nothing was more characteristic of Dr. Fringer's sincerity of purpose than his contribution, when yet a young man, out of his meagre means, of \$500, toward the erection of the Presbyterian Church at Tower Hill, of which he was an honored member and in which he was for 22 consecutive years an elder. One of the features of Dr. Fringer's life was his constant disposition to aid young men and women toward advancement in life. To aid the poor was a delight.

In the eyes of his professional brethren Dr. Fringer was a man of good judgment, modest and unassuming, and ready at all times to render service to the worthy poor. One of his colleagues says of him that he was "a man of sterling character, who never shirked duty, faithful to his country as soldier and practitioner of medicine. A man of clear and candid conviction, gentle and considerate in his dealings, a thorough and conscientious practitioner, and an honor to his profession. He followed in the footsteps of the great physician, and maintained his standing as a christian gentleman."

On September 17th last Dr. Fringer suffered a slight paralytic stroke which caused his left foot to drag—a week later another that rendered the left hand helpless. The shocks kept coming harder until the hour of his death, February the 17th. He was buried in Maple Leaf cemetery.

Dr. Fringer's family remained unbroken until he, the head, passed away. Of his family there remain, to mourn his absence, his wife, Dr. W. R. Fringer, of Rockford, Ill.; Mrs. E. G. Owens of Washington, Ind., and Mrs. J. F. Cover of Toulon, Ill.

Dr. Fringer was a member of the A. O. U. W.; G. A. R.; Pana Lodge, A. F. & A. Masons, and Pana chapter.

#### Julius Kohl, M. D.,

At the annual meeting of the Illinois State Board of Health held in Springfield, Ill., Jan. 13, 1903, the action was taken relative to the death of Dr. Julius Kohl:

Whereas, Dr. Julius Kohl, formerly an honored member of the Illinois State Board of Health, died at his home in Belleville, Ill.

Resolved, That we recognize the ability, integrity and manly courage that characterized the deceased, and the unswerving fidelity, honesty and fearlessness that animated him in the discharge of every duty while a member of the Illinois State Board of Health.

Resolved, That we tender our sympathies to the family of the late Dr. Kohl, to his immediate friends and to the citizens of St. Clair County in the irreparable loss they have so recently sustained.

#### E. T. Dickerman, M. D.

Dr. E. T. Dickerman died of acute pneumonia at Springfield, Friday morning, Jan. 23, 1903, after an illness of five days. He was born in Jacksonville, Ill., August, 1867. He graduated from Chicago Medical College in 1890, and



served two years as interne in Mercy Hospital. After studying in Vienna, he became established in Chicago as a laryngologist, and at the time of his death had reached the pinnacle of eminence in his specialty. The news of his death has occasioned the deepest sorrow among the medical profession, by whom he was widely known and fondly loved. The funeral occurred on Sunday, January 25th, in Springfield and was attended by a large number of his colleagues and friends from Chicago as well as by the members of the Sangamon County Medical Society.

#### EXECUTIVE COMMITTEE.

At a meeting of the Executive Committee called by President Harris for January 8th, at the Athletic Association Rooms, Chicago, the following members of the Judicial Council and of the Society were present by invitation: J. F. Percy, O. B. Will, Carl E. Black, H. C. Mitchell, W. O. Ensign, E. J. Brown, C. B. Johnson, J. W. Pettit, C. W. Hall, C. C. Hunt, E. L. Reat, Joseph B. DeLee, W. A. Evans, D. W. Graham and R. R. Campbell. Present of the Executive Committee, M. L. Harris, W. K. Newcomb, George N. Kreider, J. H. Stowell, W. E. Schroeder and E. W. Weis.

The object of the meeting was stated by President Harris in a very exhaustive and convincing argument to change the annual dues of the members to an annual per capita assessment of the local societies, which said assessment would cover the membership dues of the State Society and also of the American Medical Association.

After a full, free and thorough discussion of the subject, the following was moved by Pettit and seconded by Black and unanimously adopted: "That it is the sense of this meeting that one assessment cover the dues of the county, state and national societies. Carried unanimously.

The following motion made by Campbell and seconded by Pettit was also carried unanimously: "That it is the sense of this meeting that the Constitution of the Illinois State Medical Society be changed to the plan of assessing annually the county societies *per capita* in place of the individual dues as now exists."

The following motion was adopted, moved by Johnson and seconded by Pettit: "That

it is the sense of this meeting that the annual assessment of the local organizations by the State Society, shall be \$2.00 per capita of which \$1.75 be retained by the State Society, this sum to cover the subscription for the Journal and all other expenses." Carried.

The following motion by Black was also carried unanimously: "That it is the sense of this meeting that an assessment of twenty-five cents per capita of the Illinois State Medical Society by the American Medical Association should be sufficient to pay membership in the American Medical Association."

The following motion made by Black and seconded by Stowell was also carried: "That the officers of the State Society urge upon the officers of the county societies the necessity for immediate action relative to the adoption of the changes of the Constitution to the assessment plan." Carried unanimously.

In this connection the reason for immediate action was given to be that by the adoption of the various new methods suggested that at the next meeting of the Illinois State Medical Society full representation will be secured in the national body. Thus it becomes imperative that each local society should adopt the plans suggested before said meeting.

Adjourned.

E. W. Weis, Secretary.

#### THE ASSESSMENT PLAN.

The following letter has been sent to each local society in the State:

Dear Doctor:—

You are undoubtedly well aware of the rapid progress which the reorganization of the medical profession throughout the whole country is making. Illinois in this, as in all educational matters, has taken a very active interest, and it is the earnest desire of the officers of the Illinois State Medical Society to be able to present our Society at the next meeting of the National Association at New Orleans in May, as a model of professional unity.

The end toward which we are all working is that every reputable physician in the United States should become a member of three societies, namely, his local county society, his state society, and the National or American Medical Association.

In order to obviate the necessity, incon-

venience and expense of paying dues to all three of these societies, it is the intention that each member shall pay but one due, and that to his county or local society, and that membership in his county society shall carry with it membership in the State Society, and membership in the State Society shall make him a member of the American Medical Association.

The American Medical Association, in order to meet its necessary expenses, will assess the State Society a small sum, we believe not to exceed twenty-five cents per capita, and the State Society in turn to meet its expenses, including its assessment by the American Medical Association, will assess each County Society a small amount per capita.

At a recent meeting of the Executive Committee, the Judicial Council and a number of other physicians from throughout the State, which was called by the President, it was unanimously agreed that for the coming year an assessment of each County Society of \$2.00 per capita would meet the necessary expenses of the State Society, including the publication of the State Journal. In order to bring this about it will be necessary to change slightly the present constitution of the State Society, by eliminating entirely from it the provision for the \$3.00 annual dues, and to provide for the assessment plan. This we expect to do through the House of Delegates at our next meeting in Chicago the last of April. It will also be necessary for each County Society to make provision in its constitution to pay to the State Society its assessment of \$2.00 per capita.

Now, Doctor, we wish to secure your earnest co-operation and aid to help us bring about this great advancement in organization. We wish you, as officer of your County Society, would present this matter to your Society at its next meeting, or should you not have another regular meeting before the first of April, call a special meeting for the purpose. It will only be necessary for you to change your constitution and by-laws to permit the payment of the annual assessment of \$2.00 per member to the State Society whenever its Treasurer calls for it, and to arrange the amount of your own dues. The dues of your County Society should be \$2.00 **plus** any amount you may need or desire to run your own Society. If you can run your own Society for a dollar a year per member, then fix your dues at \$3.00 a year. There will be **no other dues** for your members to pay, but the one due of \$3.00 will make each one a member of your County Society, of the State Society, and of the American Medical Association, and each one will get the Illinois State Medical Journal free, or in other words, the assessment to the State Society pays for one's membership and for his subscription to the State Journal. The State Journal, as you know, is rapidly becoming a strong and influential Journal, and will soon publish the proceedings of all the County Societies, as well as those of the Chicago Medical Society.

Our reason for urging you to prompt ac-

tion in the matter is that we may secure the adoption of these changes in all the counties in the State before April. We also desire that your Treasurer, or your delegate whom you send to the next meeting of the State Society, will be authorized and prepared to pay your assessment for the coming year at our next meeting in Chicago, April 29th to May 2d.

This will be necessary if Illinois is to seat the number of delegates to which she is entitled to the next meeting of the American Medical Association at New Orleans, on May 5th.

The assessment plan is rapidly meeting with favor in the different states throughout the Union, and will soon be universal. We want Illinois to be in the lead. The American Medical Association has not acted on this plan yet, but we hope to bring it before the Association at the next meeting in New Orleans, and that is why we are so anxious to get our State Society well organized at our meeting in April.

If there is anything about the plan that you do not thoroughly understand, if you will write to the President or Secretary, they will be very glad to give you any further information possible, or will send some one to you who understands the matter and who will help you organize.

Trusting you will please give this matter your earnest and prompt consideration, we remain,

Yours very truly,

M. L. Harris, Pres.

E. W. Weis, Sec.

## State Items.

The annual meeting of the State Board of Health was held January 13, 1903, at the State House. George W. Webster, of Chicago, was elected president; J. A. Egan, of Springfield, re-elected secretary, and J. C. Sullivan, of Cairo, treasurer.

No action was taken regarding proposed legislation, as the desires of the board were fully covered in the annual report delivered to Governor Yates January 1st.

The members of the board present were: George W. Webster, W. O. Forbes, W. H. Hipp, of Chicago; Henry Richings, Rockford, and C. B. Johnson, of Champaign. A. S. Shaw, of Chicago, attorney for the board, also attended.

By the will of Rosa Buehler, probated recently in Chicago, an estate valued at \$100,000 is divided. Charity bequests are made as follows:

The German Hospital.....	\$1,000
Uhlich's Lutheran Hospital.....	500

The Chicago Ambulance Corps cared for 10,143 sick and injured persons during the year 1902.

In the management of Cook county affairs the most important work of the year was the reorganization of the Dunning institutions on

the recommendation of a special committee composed of Frank Billings, Hugh T. Patrick, Miss Julia C. Lathrop, Mrs. John M. Moulton, Ernest P. Bicknell, and five county commissioners. The \$500,000 bond issue recently voted will be used in making improvements in the county institutions.

The population at Dunning at the close of the fiscal year, Dec. 1, 1902, was: Insane asylum, 1,632; poorhouse, 1,030; consumptive hospital, 94; total population, 2,756.

The health committee of the Chicago city council has reported favorably the "undertakers' ordinance" and will ask the council to pass it. The principal idea of this ordinance is to prevent trafficking in bodies, it being provided that no hospitals shall deliver bodies to undertakers within twenty-four hours of the time of death without written permission from near relatives of the dead person; also all hospitals must provide suitable morgues for the proper preservation of bodies.

The object is to prevent hospital authorities from sending bodies to favored undertakers before notifying relatives of the death so that when the relations call to claim the bodies they naturally employ the undertaker to conduct the funeral.

It is also provided that all undertakers with whom bodies are left by police or coroner must within twelve hours notify the health department of receiving such bodies.

D. R. Brower and Nicholas Senn of the University of Chicago and several professors of the department of medicine have been granted leave of absence for a month to take an extended trip through the tropics. They will visit Martinique, the Bahamas, and cruise in the Caribbean sea. The trip will be one continuous cruise. No stop longer than twenty-four hours will be made at any point.

G. N. Stewart, head of the department of physiology in the western Reserve University Medical School, Cleveland, O., has been elected head of the department of physiology in the University of Chicago, to take the place of Jacques Loeb, who has gone to the University of California. Prof. Stewart will begin his work at the university on April 1.

During the year just closed the Visiting Nurses' Association of Chicago cared for 5,474 new cases, some of them receiving daily visits throughout the year. This statement was contained in the annual report of Harriet Fulmer, who is in charge of the nurses, which was read at the association's annual meeting.

"The Society of Visiting Nurses," continued the report, "stands as an educational factor in teaching the people in their own environment the care of their own sick and the right observance of the sanitary laws; meets the great inadequacy of the county and city institutions, which are intended for the indigent sick, and deals with such cases, for which no institution provides, giving the same skilled nursing

care as the rich may provide for themselves.

St. Anthony's Hospital building at 28 Frankfort street, Chicago, recently became the property of John F. Labahn, president of the Labahn Brick Company, who purchased the building for \$23,000 at a sale ordered to satisfy a mechanic's lien. The hospital has been operated by Bishop Anthony Koslowski and the Independent Polish Catholic church, and the case involved a lien which had been pending for three years.

The following bills of interest to the profession have been introduced in the Illinois Legislature:

Fowler—Repealing the act to establish boards of health in counties not under township organization.

Norden—To regulate the practice of professional nursing of the sick. The bill provides for the creation of a State Board of Examiners of registered nurses, composed of three members, to be appointed by the governor from twelve nominations submitted to him by the Illinois State Association of Graduated Nurses. All professional nurses are required to submit to an examination before this board as to their qualifications.

Davis—Amending the child labor law by providing that any person, firm, or corporation violating the act shall be fined not less than \$5 nor more than \$100 for each offense.

The State Board of Charities held a meeting January 16. The board has decided to ask the legislature to authorize it to select a site for the proposed state epileptic colony and a bill to this effect is in course of preparation.

We have no hesitation in calling the attention of our readers to the advertisement of C. F. Meyer & Co., collectors, 1410-1412 Ashland Block, 59 Clark street, Chicago. These gentlemen have been engaged in this business for nearly 15 years and have collected for hundreds of professional men in Chicago to whom they refer. They charge no membership fee and unless there is a court cost ask nothing until the money has been secured. Our members, many of whom have suffered at the hands of fraudulent collection agencies, will do well to communicate with this firm when in need of expert assistance.

#### BOOK REVIEWS.

A Nurses' Guide for the Operating Room, by Nicholas Senn, M. D., LL. D., W. T. Keener & Co., 90 Wabash ave., Chicago.

This manual of 128 pages will be found a most desirable work for every surgeon and surgical nurse. It will be found to fully fulfill its aim which the author states is to instruct the nurse in as concise and thorough a manner as possible in the details of her responsible duties before, during and after



operations. The technique of asepsis is given a prominence commensurate with the importance of the subject. We can recommend the book in the highest terms. Several hospitals we know have supplied a copy of it to each of the surgical nurses.

**Uveitis**—Symposium of Papers read before the Ophthalmological Section of the American Medical Association at the Saratoga meeting, 1902. Assn. Press, Chicago.

This work of 91 pages contains seven papers bearing on this subject from the pens of seven of the leading ophthalmologists of the country, two of them, W. H. Wilder and T. A. Woodruff, of Chicago. Our readers who desire to keep in touch with the latest views on this subject should read this work.

A Manual of Medical Treatment or Clinical Therapeutics, by I. Burney Yeo, 2 volumes, 10th Edition, 15th Thousand. W. T. Keener & Co., 90 Wabash ave., Chicago.

The fact that this manual has gone through ten editions in 9 years proves its great value. It is filled with valuable observations on the treatment of disease and should be in the hands of every careful practitioner of medicine.

### Local Societies.

The Christian County Medical Society met in the Circuit Court room, Taylorville, Jan. 15, 1903, in regular session at 2:30 P. M. President J. N. Nelms in the chair.

Upon motion of W. K. Wright it was ordered that the secretary and president act as the program committee.

Committee on Constitution and By-Laws submitted by J. P. Simpson the constitution and by-laws recommended by the American Medical Society, for local societies and it was adopted.

A. F. Hammer read a paper on **Diphtheria**, its cause and treatment.

W. K. Wright read a paper on **Tonsillitis** and its treatment.

C. L. Carroll read a paper on **Smallpox** and its treatment.

T. M. Johns read a paper on **Measles** and its treatment.

The names of the members of the Society are: J. N. Nelms, M. M. Hill, D. F. Morton, F. E. North, W. K. Wright, A. F. Hammer, J. H. Dickerson, C. L. Carroll and G. F. Meacham of Taylorville; M. W. Staples, Grove City; J. P. Simpson, J. F. Miller, Palmer; C. W. Coe, W. T. Short, W. T. Bridges, Stonington; C. H. Stokes, Edinburg; J. H. Miller, Pana; W. H. Frazer, Pana.

We hope to make The Christian County Medical Society one of the best in the State. Next meeting about the middle of April.

W. T. Bridges, Official Reporter.

The East St. Louis Medical Society convened at 8:30 P. M., November 24th, 1902, with J. W. Rendleman, President; C. W. Lillie, Secretary pro tem., and members Grimes, Campbell, Whitmer, Hanson and Housh; and visitors, Drs. F. E. Cox, J. G. Battell and J. D. Nifong.

C. W. Lillie presented a case of **Rachitis** in a colored female child two years of age. The patient learned to walk a little at one year, but in a short time "stopped walking all at once," and from that time even refused to stand, and up to this time had made no further effort in that direction.

The lower extremities were straight and fairly well nourished, and showed but slight enlargement at the ankles. The head showed the characteristic features of the disease. Small nodules were found upon the ribs, but the lower extremities of the bones of the forearm all showed marked enlargement.

The child appeared to be fairly well nourished, and there was but little enlargement of the abdomen.

The case elicited some discussion and the conclusion was reached that the case was a hopeful one.

The names of J. G. Battell, J. D. Nifong and F. E. Cox, were presented for membership and referred to the Board of Censors.

The Pulaski County Medical Society met in regular session at the office of J. F. Hargan in Mound City, Ill., Tuesday, January 6, 1903, with the following physicians present:

A. W. Tarr, Hall Whiteaker, W. J. Whiteaker, Monroe Doty, W. C. Rife, L. F. Robinson, J. B. Mathis, Sr., J. F. Hargan, C. B. Powell and C. J. Boswell.

After the transaction of routine of business, the following resolutions were read and adopted:

Resolved, That The Pulaski Medical Society hereby heartily approves and endorses the proposed bill for the regulation of the practice of medicine and the establishment of a board of medical examiners in Illinois.

The subject of obtaining pay for birth reports examination of the insane and other services, which are to be paid out of the county treasury, was brought before the society and discussed at length resulting in the president appointing a committee of three to wait on the board of county commissioners and that when physicians render services to the county that they are to be paid accordingly.

The scientific part of the program was taken up and the following papers read and discussed:

**Catarrhal Jaundice**, A. W. Tarr. Discussed by Drs. Boswell, Whiteaker, Sr., Whiteaker, Jr., Hargan, Robinson, Doty, Rife, Winstead and closed by the author.

**Typho-Malarial Fever**, C. B. Powell. Discussed by Drs. Doty, Rife, Robinson, Boswell, Mathis and Winstead.

**Report of Some Surgical Cases**, L. F. Robinson. Discussion, Dr. Rife, and closed by the author.

**Bronchitis in Childhood**, W. C. Rife. Discussed by Drs. Hall, Whiteaker, Boswell, Robinson, Mathis, Powell and closed by the author.

There being no further business the society adjourned to meet again in Mound City, Ill., the first Tuesday in April.

Chas. J. Boswell, Official Reporter.

**The Washington County Medical Society** held a meeting in Nashville on January 8, 1903, and effected a permanent organization and elected the following officers: L. T. Granay, of Irvington, president; R. E. Vernor, of Nashville, vice president; S. P. Schroeder, of Nashville, treasurer, and J. J. Troutt, of Nashville, secretary. David Neer, of Beaucoup; W. D. Carter, of Nashville, and L. P. Schroeder, of Addeville, were appointed on the board of censors.

On account of the bad roads our attendance was small, there being only seven present.

S. P. Schroeder read a very interesting paper on the **Differential Diagnosis of Heart Disease**, and presented a case which proved to be very interesting to the members present.

The Washington County Medical Association will meet quarterly the second Thursday in January, April, July and October.

J. J. Troutt, Official Reporter.

**The Stephenson County Society of Physicians and Surgeons** held its regular quarterly meeting in Freeport, January 8, 1903, President J. F. Fair presiding.

The minutes of previous meeting stood approved as read.

J. N. Daly of Orangeville was elected to membership in the society.

The names of Wm. Karcher of Freeport, graduate of the University of Philadelphia, 1900, and J. D. Garrett of Orangeville, graduate of Physicians' and Surgeons', Chicago, 1902, were proposed for membership by Drs. Martin and Hutchins.

Secretary and treasurer's report was accepted.

R. J. Burns introduced a resolution to change Secs. 2 and 3 of Art. 3 of local society's constitution, to conform with Sec. 7, Art. 3 of Illinois State Medical Society's constitution, which will according to rules come up for final action at next regular meeting.

#### Program.

At 10 A. M. L. G. Voigt operated at St. Francis' Hospital for radical cure of inguinal hernia.

At 1:30 P. M. The society convened at the court house.

J. H. Stealy contributed a clear and exhaustive paper on **Ectopic Gestation, Etiology, Symptoms, Diagnosis and Treatment**.

W. J. Rideout read a carefully prepared paper on **Ocular Headache**, devoting special attention to diagnosis and treatment.

Both papers and clinics were discussed generally by the members present and proved interesting and instructive. Adjourned.

Robert J. Burns, Official Reporter.

**The Physicians' Club of Jacksonville** at its first regular meeting of the year elected the following officers:

President—Frank P. Norbury, three months.

Vice President—A. L. Adams, three months.

Secretary—David W. Reid, one year.

Treasurer—E. F. Baker, one year.

David W. Reid, Official Reporter.

**The Morgan County Medical Society** met in regular monthly session on November 13th, 1902, with F. P. Norbury in the chair, in the absence of both president and vice president.

The minutes of the October meeting were read and approved.

The appointments for the December meeting were announced by the chairman as follows:

Adenoids: Drs. Adams, McLaughlin and Gailey. Leaders: Drs. Hairgrove and G. E. Baxter.

The election of officers for 1903 and the reports of the retiring officers will be a feature of the meeting of December 11th, 1902; also the future of the Journal of the Society will be considered.

Members present: Drs. Bradley, of Waverly; Maness, of Nortonville; Miller, of Woodson, and Drs. Adams, George E. Baxter, Flickwir, Norbury and Wakely, of Jacksonville.

Dr. Duffield, of Pittsfield, was present as an invited guest, and Mr. George Stacy as a visitor.

F. P. Norbury made some remarks on the Journal of Morgan County Medical Society, explaining how the delay in publication occurs, mainly because the members do not furnish the editor with the revised copy of their papers, reports of cases, remarks, etc.

A. L. Adams reported a case of chronic enlargement of the lachrymal glands in which the cervical glands and tonsils were involved. Treatment iodides and massage.

G. E. Baxter reported a fatal case of morphine poisoning. When he saw the case the respiration was six per minute; pulse very rapid; pupils contracted and no reflexes.

Dr. Maness reported a case of typhoid fever in a child four years old, with meningeal involvement. The patient was unable to speak; temperature 106 2-5 degrees. There were brain symptoms and convulsions. Cold application and Cannabis Indica were used to control the brain trouble; pupils were sometimes dilated and at other times contracted. Dr. Miller saw the case in consultation. Temperature has been normal for the past twelve days.

Dr. Wakely spoke of the use of Cannabis Indica, giving some personal experience with this medicament.

Dr. Norbury said meningitis and toxæmia were prominent features in the case reported by Dr. Maness, and thinks that meningitis is sometimes a sequela following typhoid fever, or may accompany it.

Dr. Bradley reported a case of fractured femur detailing treatment.

Dr. Duffield advocates the use of the Hodgen splint for all fractures of the lower extremity above the knee, and spoke of remarkably good results in several cases with great comfort to the patients while under treatment.

Dr. Adams explained and exhibited an apparatus for preparing extemporaneous antiseptic solutions.

Owing to the absence of the responsables on the subject of the day, Fractures, Diagnosis and Treatment, this order was passed.

Dr. Wakely gave a demonstration on the manikin of the use of the St. Cyr. Obstetrical Tractor, an instrument to take the place of the forceps.

Dr. Duffield explained in full and demonstrated his method of resuscitation of the asphyxiated new born child. This demonstration was of great interest, and the method is a decided improvement of all other means of accomplishing this object.

Remarks on the subject were made by Drs. Adams, Norbury and Wakely.

On motion the thanks of the society were tendered to Dr. Duffield for his kindness in demonstrating his method before this society.

No further business appearing, on motion the society adjourned.

T. A. Wakely, Official Reporter,

The Morgan County Medical Society met in regular session, annual meeting, on Thursday, December 11th, 1902, at its rooms in the Hockenhull building.

Dr. Cole acted as chairman.

The minutes of the November meeting were read and approved.

The committee on proposed new Constitution and By-Laws reported in favor of the proposed Constitution and By-Laws for county Societies.

Dr. Adams moved that a committee of three consisting of Drs. Norbury, Baker and Black be appointed to report on the publication of the Journal of the Society at the January meeting. The motion prevailed and it was so ordered.

The finance committee, alias the directors, made a verbal report, giving the balance on hand to be \$34.49, as shown by the report of the Treasurer.

The election of officers for 1903 resulted as follows:

President—T. A. Wakely.

Vice-President—W. K. McLaughlin.

Secretary—C. E. Burkholder.

Treasurer—E. F. Baker.

Librarian—T. J. Pitner.

Directors—T. A. Wakely, C. E. Burkholder and E. F. Baker.

Judicial Council—J. W. Hairgrove, Bowe, Gailey, Pitner and Parker.

On motion, which prevailed, the President and Secretary were elected committee on program for the ensuing year.

A. L. Adams read a paper on Adenoids.

B. S. Gailey gave an extended talk on Adenoids.

Discussion of the subject followed.

The following members were present: Adams, Black, Bowe, Burkholder, Campbell, Cole, Flickwir, Gailey, Hairgrove, Thompson and Wakely, of Jacksonville, and Dr. Parker, of Mt. Sterling.

J. M. Elder, of Franklin, and C. M. Weems, of Griggsville, were present as visitors.

On motion the Society adjourned.

T. A. Wakely, Official Reporter.

The Sangamon County Medical Society held its regular monthly meeting Monday evening, January 12, 1903, at 8:30 o'clock at the court house, with A. L. Brittin, president, in the chair and fourteen members present. The minutes of the December meeting were read and approved. E. H. Brittin of Pawnee was elected to membership in the society. The bill of the secretary for stamps and janitor service amounting to two dollars was read and ordered paid. The accounts of the treasurer for the past year were audited by the board of directors and found correct.

G. F. Steriker in his paper on Chlorosis stated that age and sex are of diagnostic importance, as it is a disease of the young female, being found more frequently between the ages of 16 and 26. The most prominent symptom being the pale or greenish tinge of the skin, whence its name, also the pale, anaemic or slightly bluish tint of the conjunctiva. The teeth are often poor, the tongue usually pale, large, flabby, indented from the teeth, furred and constipation as a rule. The urine is pale but otherwise normal. There is no fever unless complications arise, such as ulcer, thrombosis, etc. The muscles of the heart are often fatty. The cavities become dilated and systolic murmurs are apt to be heard at the different valvular orifices. In the report of a case all of these symptoms were pronounced. The estimated amount of haemoglobin in this case was about 42 per cent. With careful treatment the prognosis is usually favorable unless complications arise. Iron properly given and of sufficient quantities is the treatment.

L. C. Taylor gave a very interesting talk on Leukocythemia; also presented several blood specimens of different cases.

In the discussion M. T. Shutt said she did not always have good results in the treatment of chlorosis, the patient being prone to other diseases. She also spoke of the use of red bone marrow in the treatment. J. W. Kelly spoke of a case in which the spleen was greatly enlarged and liked arsenic in the treatment. S. E. Munson complimented the papers and thought rest was very necessary in the treatment. B. B. Griffith spoke of good results by using different forms of iron to suit the case. A. D. Taylor said that iron should be given in increasing doses, and A. L. Brittin insists on the fresh preparation of Blaud's Pill and the regulation of the bowels. After examination of blood specimens the society adjourned.

Percy L. Taylor, Official Reporter.

The Peoria City Medical Society met Tuesday evening, December 2, 1902, at the National Hotel, and was called to order by President, R. A. Hanna. The Secretary being absent, E. M. Eckard was appointed Secretary, pro tem.

The applications of J. V. Studer and R. C. Bradley were read and ordered referred to the Board of Censors.

H. H. Whitten reported for the committee on flowers for the funeral of Dr. H. Steele, and presented a bill for \$10.00 which was ordered paid.



E. M. Sutton called attention to the fact that Dr. Boal was 96 years old, and the Society had made no official recognition of it. He was appointed a committee of one to obtain a suitable offering for Dr. Boal and send it to him as a Christmas present.

H. H. Whitten then read an interesting and instructive paper on **Practical Points in Obstetrics**.

The paper was well discussed by C. E. Davis, L. A. McFadden, and the others present.

Those present were, Hanna, Will, Whiting, Roskoten, Sutton, Green, E. L. Davis, C. E. Davis, F. B. Lucas, McFadden, Whitten and Eckard. Adjourned.

The Peoria City Medical Society met Tuesday evening, December 16, 1902, at the National Hotel, and was called to order by President, R. A. Hanna.

The Censors reported favorably on the applications of J. V. Studer and R. C. Bradley, but the necessary quorum was not present so the voting was deferred until the next meeting.

The program committee reported through their Chairman, J. W. Hensley.

A motion was made by R. A. Kerr, and carried, that the report be amended by having the date for the annual banquet set for some time in April, at or about the anniversary of the Society instead of December 30th.

It was moved by M. S. Marcy that the report be received and each member be required to fill his part on the program or furnish a substitute. Carried.

Twenty dollars was voted to E. M. Eckard, for his services as Secretary during the past two years, and five dollars to Jeannette C. Wallace for her services as Treasurer during the past year.

E. M. Sutton moved that a committee be appointed to purchase Mr. Montrose a present to cost not more than \$25.00, for his kindness in furnishing the Society a meeting place free of charge.

President appointed E. M. Sutton and H. H. Whitten on the committee.

E. M. Eckard read a valuable paper calling attention to the **"Facial Expression in Disease,"** which was thoroughly discussed by Drs. Lucas, Roskoten, Kerr, Sutton, Roberts, Green and Marcy.

E. M. Sutton reported an operation for **appendicitis** with presentation of a specimen.

Robt. A. Hanna reported an operation for **appendicitis** in which bands of adhesion from a previous attack had cut off the circulation of a portion of the intestine, necessitating a resection of fifteen inches. The patient made a nice recovery.

R. L. Green reported a case of **diphtheria**.

The members present were Roskoten, Hensley, Marcy, Whitten, Kerr, Eckard, Horwitz, Shepperd, Sutton, Roberts, Hanna, Green, Lucas and Collins. Adjourned.

The Peoria City Medical Society met at the National Hotel, January 6, 1903, and was called to order by First Vice-President, L. A. McFadden.

Mr. Montrose, of the National Hotel, appeared before the Society and in a neat speech conveyed his thanks for the present received during the holiday season.

A letter was read from Carl E. Black, acknowledging the receipt of twenty-five dollars for the use of the State Committee on Legislation.

A general discussion on the **"Treatment of Tuberculosis of the Lungs"** followed in which Drs. Collins, Hensley, Sutton, Roskoten, Marcy, Kanne, E. Franc Morrill and L. A. McFadden gave their views.

There being a quorum present at this time, the Society referred back in the order of business to "Applications for Membership" and "Reports of Committees."

E. M. Sutton reported for the committee appointed to purchase a present for Mr. Montrose, that they had purchased two carriage robes costing \$20.00.

E. M. Sutton also reported that he had sent a box of the best cigars to Dr. Boal of Lacon, which cost \$4.25.

An order was drawn on the treasury in favor of E. M. Sutton for \$24.25 to pay these bills.

The application of J. V. Studer, 1327 S. Adams street, Peoria, Illinois, and R. C. Bradley, Kickapoo, Peoria County, Illinois, were voted on and they were received into the membership of the Society.

The members present were Shepperd, McFadden, Hensley, E. L. Davis, Roskoten, Marcy, Sedgwick, Horwitz, Kanne, Jeannette Wallace, E. Franc Morrill, C. E. Davis and Collins.

Adjourned.

C. M. Collins,

Official Reporter.

The Jo Daviess County Medical Society was called to order by the secretary in the parlors of the Great Western Hotel, Stockton, January 15, 1903. A telegram was read from President Godfrey expressing his inability to be present. On motion Wm. Hutton was elected president pro tem.

Roll call showed the following members present: Stafford, Egan, Smith, I. C., Hutton, Eade, Lewis, Smith, D. G., Phillips, Czibulka, Sharp, Kreider, Wright, with J. C. Hancock of Dubuque, Iowa, A. T. Nadig of Nora, J. H. Stealy and E. H. Best of Freeport, and E. F. Grubbs of Columbus, Ohio, as visitors.

Minutes of previous meeting read and approved.

The proposed bill for the regulation of the Practice of Medicine was then taken up, after some discussion. The following motion was made and carried: **That this society approve and endorse the proposed bill for the regulation of the Practice of Medicine and establishing a Board of Medical Examiners in the State of Illinois.**

A second motion was made and carried that each member present donate one dollar to the Legislative Committee for the prosecution of this bill and that it be paid to the secretary for him to forward to the committee. The following contributed one dollar each: Wm. Hutton, N. S. Lewis, T. J. Stafford, S. G.

Kreider, A. C. Czibulka, C. E. Wright, J. C. Egan, J. M. Sharp, A. T. Nadig, T. M. Eades, I. C. Smith, D. G. Smith, A. C. Phillips. Total, \$13.00.

Applications were received from J. C. Hancock, Dubuque, Iowa; A. T. Nadig, Nora; J. H. Stealy and E. H. Best, of Freeport.

A motion was made to suspend the constitution and elect the above applicants by acclamation. The motion carried and they were declared elected to active membership.

T. J. Stafford then presented a very interesting case of **Pseudo-Hypertrophic Paralysis in a Child of 2 Years.**

J. H. Stealy of Freeport then read a very interesting and instructive paper on **Ectopic Gestation, Etiology, Diagnosis and Treatment.** In this paper the doctor very clearly shows that this malady is very often overlooked and all kinds of diagnosis made except the right one. That the number of cases are far more numerous than reported and yet a large number of old practitioners claim that they never saw a case. Space will not permit a full review of the case.

A vote of thanks was given him for his valuable paper.

Warren was selected as the next place of meeting for April 15th.

The subject of **Para Typhoid** was touched upon, and the various similarities and yet marked differences pointed out.

At this hour the Stockton physicians invited the society to dinner and an elegant repast was served, to which all did justice. A. C. Phillips delivered the toast of the evening.

A short session was held in the evening and Dr. Nadig presented a child of 2 years of age with **Infantile Paralysis**, after which a general discussion was indulged in.

Adjourned.

D. G. Smith, Official Reporter.

The **Vermilion County Medical Society** met January 12th in the City Hall, Danville. Called to order by the president, H. F. Becker.

Minutes of the December meeting read and adopted.

The board of censors reported favorably on the names of I. E. Huston, Geo. L. Prentice and J. A. Chaffee, followed by their election to membership. The name of A. M. Miller was presented and handed to the censors.

The paper of the evening was on **Influenza**, by J. H. M. Clinch, which brought out a general and interesting discussion.

Following the paper was a discussion on unprofessional conduct lead by Jos. Fairhall.

He referred to the codes of ethics that have governed the medical profession from the earliest days to the present, and wound up by stating that a Danville physician and member of the society had come under suspicion as having violated the code by consulting with a quack. The doctor pulled from his pocket a book containing the code of ethics at present adhered to by reputable physicians, and between its leaves found several clippings from newspapers from which he proceeded to read extracts of a more or less disgusting nature.

They were advertisements of "advertising doctors" giving the names of persons alleged to have been cured, and suggesting treatment for various diseases whose names are not commonly discussed about the firesides of our citizens. He said he could not blame the newspapers, for they were in the space selling business and make their living by advertising whoever comes along and pays for the space.

T. E. Walton was then called upon and addressed the meeting at some length. He deplored the necessity of calling the attention of his fellows to the conduct of one of their number in consulting with, and accepting cases from one of the local "advertising doctors." He thought there was no necessity for any "reputable" physician to call upon these practitioners. The whole society stands ready to come to the aid of their brethren. He then said that it was Dr. X who was referred to by Dr. Fairhall, and whose conduct was the subject of discussion.

Dr. X said he understood that the matter referred to was one in which a case had been turned over to him by an "advertising" doctor, a surgical case. He had consulted with Dr. Glidden concerning the matter, and the latter had advised him to take the case under certain conditions.

Dr. Fairhall said that was not the case to which he referred. It was that of a woman who had been treated by the "advertising" doctor. The latter had called Dr. X into consultation, and he had gone with the "advertising" doctor to her home and treated her with the assistance of the latter. He thought Dr. X had erred by having anything at all to do with the person who advertises his cures, and is classed as a "quack" by members of the society. There was no personal feeling against Dr. X, nor was there any feeling other than a desire to administer a friendly reproof.

Dr. X said he had been called in the case referred to and finding that it was a grave one, and desiring to consult with someone else concerning it, he had consulted the wishes of the family and they desired him to get the "advertising" doctor and he had done so. The family said the latter doctor was their family physician, and he did not consider it a violation of the code of ethics in doing what he did in the matter. He might have committed a technical error, but had not intended to transgress the laws that have governed the profession for centuries.

Walter Brown was called upon and told of the time he had been called upon to treat a young man dying of pneumonia in a hotel by a doctor looked upon as a quack by local practitioners, but said he had at first declined, telling the quack his reasons therefor. The dying man's brother then dismissed the quack and turned the case over to him. Although he had accompanied the quack to the hotel, he had not consulted said quack, and the latter was not in the room when he examined the patient and prescribed. Later he realized that he might have stepped over the boundary slightly, but thought the circumstances justified his actions.



Dr. Walton was very emphatic in stating that reputable physicians would have to live up to the code of ethics laid down for them or throw it to the winds and abandon all pretense of doing so. He said the class of doctors referred to as quacks or advertising physicians, are not the ones that will get up during the night to assist in a difficult case, will not stand at the bedside of sufferers and face death with their brother practitioners, but wanted only to rake in the easy money that comes to them in the daytime. He advised his fellow doctors to refuse to have anything to do with them, not to accept any cases from their hands or any other favors. He would not be seen walking down the street with one of them.

Secretary Clark said he would not accept a case from one of them—would not admit their right to practice at all—in fact would utterly ignore them in every particular.

The proposed bill to regulate the practice of professional nursing in the state was discussed and received the unanimous indorsement of the society.

Adjourned.

E. E. Clark, Official Reporter.

The St. Clair County Medical Society held its regular quarterly meeting December 4, 1902, at Priester's Park, with President Fairbrother in the chair and the following members present: Gunn, Hansing, Lillie, Rembe, W. West, Jr., Starkel, Hertel, Rayhill, Cox and Portuondo, and as visitors Little, Benson and Kluthe.

Minutes of the preceding meeting were read and approved.

Report of treasurer was received and approved.

C. H. Starkel rising to a question of personal privilege said that a short time previous he had been the victim of a very unpleasant and disagreeable incident. Without his knowledge or consent a friend of his had used his name in connection with an advertising scheme. On learning of it, he had at once taken all the steps that he could to stop the advertisement from appearing, but unfortunately two or three papers had already been printed and therefore he was not able to stop those. He had written a card to the Journal of the American Medical Association and the Journal of the State Society disclaiming any connection whatsoever with the advertising scheme. And he also asked the society to enter his disclaimer in the minutes of the meeting, which was so ordered by an unanimous vote.

Applications for membership were received from E. H. and H. M. Little. On motion the rules were suspended and the gentlemen elected to membership by acclamation.

Dr. Portuondo and Hansing moved that a legislative committee of three be appointed by the president. Approved.

C. W. Lillie moved that the bill of the State Society creating a Board of Medical Examiners be endorsed by the Society. The motion was unanimously approved. Dr. Lillie was also appointed to see the members of the legislature from this county in the interest of the bill.

C. W. Lillie also moved that a committee of three be appointed to prepare and recommend to the society such amendments as should be necessary to make the by-laws of the St. Clair County Medical Society correspond as far as necessary with the new by-laws of the State Society. Approved.

C. H. Starkel presented a specimen of **ectopic tubular gestation** with the following history: Patient was a well developed, strong, healthy woman, 31 years old, married 9 years and sterile. Menstruation was always irregular, and scanty, sometimes two, three or even six months would intervene between two menstrual periods. She was out one afternoon and on returning home at 7:30 P. M. was taken suddenly with a very severe abdominal pain radiating to the rectum and great deal of tenesmus. Several attempts at defecation proved futile. Pulse 86 and strong, temperature normal, no syncope, cheeks and lips red. A vaginal examination showing no bulging in the cul de sac of Douglas. She was menstruating slightly and according to her statement had been doing so for three days. She menstruated last in September, missed in October and menstruated again in November, the present period. At 10 P. M. good pulse, no temperature, complained of gas in the abdominal cavity that moved up to one place and not being able to pass any further would move back again. There was some tympanites. At 8 A. M. next morning pulse strong, 100, no syncope, some tympanites. At 12:30 she had a fainting spell, pulse 120. Soon afterward another fainting spell. Patient was now pale and arrangements were made to operate on her. She was removed to the hospital, reaching it at 2 P. M. A saline injection was given, but it was not absorbed. Preparations for the operation were made and at 3:30 P. M. all signs of collapse appeared and she died before he had begun to operate. A post-mortem was made shortly afterwards when three quarts of free blood were found, so that she must have begun to bleed at 2:30 P. M. Besides this, numerous clots were found. The foetus was not found. The rupture occurred in the tube near its uterine end. Dr. Starkel thinks that there was a rupture first and that the vessel was very likely closed by a thrombus and that the removal to the hospital, or moving in bed, or for some unknown cause the thrombus was dislodged and the second and fatal hemorrhage took place. He called attention to the fact that the majority of cases give more time and more symptoms than this one did. These cases are often unrecognized.

Dr. Rembe related two cases and in these there was rapid pulse, 150 to the minute, sub-normal temperature, cold clammy skin. They appeared to be completely exsanguinated; there was bulging in the cul de sac. Both cases were operated upon and made good recoveries.

Dr. Fairbrother said that a good many cases died without a diagnosis being made. It is possible to have rupture and then for the foetus to grow in the abdominal cavity. He recited such a case. Diagnosis was made at



the fourth month and patient decided to wait until severe symptoms should appear. At the eighth month there were symptoms of syncope. An operation was performed and foetus lived for eight hours.

C. W. Lillie read a very exhaustive, practical and interesting paper on the "**Early Symptoms and Diagnosis of Typhoid Fever,**" and Dr. Hertel part of a report of a case of **Typhoid Fever**. Having to reach home at a certain time, Dr. Hertel was able to read but a small part of a very complete report of his treatment of that case.

The society adjourned to meet again next March.

B. H. Portuondo, Official Reporter.

**The Aesculapian Society of the Wabash Valley** held its 56th annual meeting October 30, 1902, at Paris.

The first paper, entitled **My Experience of Three Years With the Roentgen Ray**, was read by W. J. Eddy of Shelbyville. He said: "The subject I present to you today is not a series of brilliant results but some of the difficulties I have experienced in the use of the Roentgen Ray in general practice—I first used a Fessenden coil machine run from a 110 volt street light circuit. The machine did very good work but was very expensive to run and the current was so powerful that it required great caution to avoid serious shock and burns from it and then the machine could be used only for X-Ray work. I soon put in a static machine that I have found very satisfactory as a therapeutic agent aside from the X-Ray attachment.

My troubles did not end with a change of machine they still continue to some extent. The greatest difficulty I have had to contend with is the Crook tube. They are expensive and often disappointing, you never know for a certainty what a tube is going to do. It will one day work to perfection and then not scarcely at all and perhaps in a day or two, work again all right. I found that an ordinary one would not stand all the current my machine would generate to be forced through it so I have found it economy to separate the poles of the machine only far enough to bring the tube to a bright glow and if the current becomes too strong a spark will leap across between the poles and save a strain on the tube. I have not had a puncture of a tube since I adopted this plan and have had just as good light. The volume of the current can also be reduced by lessening the speed of the machine. Another source of annoyance is the increasing resistance that comes in a tube from using it, it sometimes glows up very fast and after a few times using it will not glow with any current but will sputter and snap and if the current is forced too strong will puncture; this I had occur once.—The tube that I find of greatest service is the best German tube.—A point to be remembered in taking a picture is that we are only taking a picture of a shadow and we must see that the shadow from the light does not fall outside the plate;—I find it best never to be too sanguine in telling my patients what I will show them.

In conclusion allow me to say that the X-Ray is a good thing to have as an aid to diagnosis but it is an expensive thing and does not bring in the money that a person might be led to believe it would and it is very often a source of disappointment.

I can see how in the hands of a quack or charlatan it could readily be made a means of great deception and could play a very important part in aiding them in their nefarious work."

The paper was received for discussion.

Dr. Montgomery thought that the use of the X-Ray often simulates a species of disreputable practice.

Dr. Newcomb thought the appearances of an X-Ray shadow are very misleading. He has seen two cases of epithelioma cured by the use of the X-Ray.

Dr. Eddy in closing the discussion said "I have seen no cases of carcinoma or sarcoma that have been cured by the rays but in that class of cases the X-Ray will relieve pain. It is of no benefit in Tuberculosis or tubercular glands."

H. N. Rafferty reported a case of brain tumor in which a diagnosis was made but no operation.

J. A. Baughman presenting a paper entitled **Acute Intestinal Obstruction** said it matters not to what the obstruction is due to impaction, strangulation, volvulus, adhesive bands, invagination or what not, the symptoms in acute cases are always the same. Pain, vomiting, shock, obstipation, retention and suppression of urine are the most important symptoms, but it is the degree or intensity of the symptoms that our diagnosis hinges upon.—The patient will often be deceived as to the exact location of the trouble, the umbilical region often being referred to when in reality the seat of the trouble is remote from that area.

In acute obstruction it may be said pain is never absent and is very apt to be of a progressive intensity.—In case you do not operate in two or three days the pain will sometimes suddenly cease, often leading the unexperienced to the belief that there is an improvement in the case, when in reality it means a complete sensory paralysis of the involved nerves. Do not forget that point. Vomiting is sure to occur in acute obstruction and it never ceases.—The act of vomiting, after the first few hours of the onset, the muscular efforts of the patient, convey a constant characteristic ear mark of obstruction.—It is not the convulsive heaving emesis that we so often see in less severe affections but more of an eructation or regurgitant movement,—I have I think seen this peculiar vomiting in cases of diffuse purulent peritonitis of a severe type, but in these cases no doubt angulation has taken place thus virtually constituting an obstruction.—The vomiting in these cases is due to shock. It (shock) is one of the very important symptoms of acute obstruction. It is an effect produced on the nervous system by a profound irritation of the peripheral nerves.—The shock of obstruction is that of extreme depression rather than that of excitement.

Feeble rapid pulse, compressible arteries, cold and pale skin quick shallow respiration and often sub-normal temperature constitute a very good picture of what is known as shock.—Now that we have diagnosed the case, what next. Operate of course." The paper was discussed.

Dr. Hoff thought that adherent prepuce was a cause of intestinal obstruction in children.

Dr. Eddy believed that an operation should not be undertaken after shock became pronounced.

The next paper was read by J. P. Worrell on "**Entropion and Distichiasis.**"

"**The Spectroscope as an aid to Diagnosis**" was the title of a paper read by F. E. Wiedemann.

Dr. Schell made an extemporaneous talk on "**The Use of the Microscope as an Aid to the Early Diagnosis of Uterine Cancer.**"

James Miles read a paper on "**The Complications of The Lying-In State.**"

W. E. Bell reported a case of **Brain Surgery**. While operating for fracture of the skull the doctor accidentally lost a piece of metal from his instrument. Although very much worried for some time the patient recovered with no loss of function. Experiments made on dogs showed that clean foreign bodies soon become encysted in the brain substance and will not then interfere with the brain function.

The Censors reported favorably on the following applicants who were all elected to membership:

Albert G. Gumm, Oakland.  
Roy F. Rogers, Shelbyville.  
F. N. A. Hoffmann, Teutopolis.  
A. S. Wall, Champaign.  
W. W. Williams, Mattoon.  
E. S. Asbree, Humbolt.  
H. V. Anderson, Coles.  
G. W. Tucker, Dana, Ind.  
W. E. Rice, Tuscola.  
Edward Pearce, Marshall.  
L. Gray, Champaign.  
P. M. Little, Janesville.  
Thos. P. Williams, Rardin.  
B. K. Menefer, Oakland.

At six o'clock the society adjourned and the members were escorted to the banquet hall of the Masonic Temple where the annual society dinner was served. As they ate orchestra music filled their ears and after dinner the members repaired to the lodge room adjoining where an allround good time smoker was enjoyed.

Vice-President Larkins called the society to order and the election of officers followed:

President, W. K. Newcomb, Champaign.  
Vice-Pres., W. T. Moorhead, Terre Haute, Ind.  
Secretary-Treasurer, H. McKennan, Paris.  
Censors: C. B. Johnson, Champaign; H. N. Rafferty, Robinson; C. S. Laughlin, Paris; J. L. Reat, Tuscola; F. E. Wiedemann, Terre Haute, Ind.

The next meeting will be held at Tuscola, May 28, 1903.

H. McKennan, Official Reporter.

The regular monthly meeting of the **Adams County Medical Society** was held in Quincy, January 12th, at the Conservatory of Music.

President Gilliland and later Vice-President E. B. Montgomery presided.

The following members were present: L. B. Ashton, F. T. Brenner, C. D. Center, R. J. Christie, Jr., W. E. Gilliland, T. B. Knox, E. B. Montgomery, F. E. Nichols, L. H. A. Nickerson, Wm. Sigsbee, E. H. Toole, Sarah Vasen, J. G. Williams, W. W. Williams, O. F. Wellenreiter and John A. Koch.

The committee on public health and legislation reported progress.

The application of Virgil McDavitt of Quincy was received.

C. D. Center reported a case of **LaGrippe with a fatal complication of acute nephritis**. Oedema pulmonum being the immediate cause of death.

L. H. A. Nickerson reported two cases of **fracture of the humerus in the infant at birth**. The first was one caused by pressure of the humerus against the pubic arch, during delivery; the mother having a somewhat contracted pelvis. The second case was caused by traction with the finger in the axilla. Uneventful recovery occurred in both cases.

E. B. Montgomery, R. J. Christie, Jr., and Sarah Vasen also reported cases of fractures at birth and birth palsies.

F. E. Nichols reported a case of **insidious oncoming of bone disease**. The disease in this case was three years in making any manifestations outwardly; having no pain, but only stiffness in the limb. The necrosis occurred in the first phalanx of the big toe. It was found that the 2d phalanx, meta-tarsal and tarsal bones were involved and also the tibia and fibula for two-thirds of their length. Amputation at the knee arrested further progress and recovery resulted. Tuberculosis was given as the cause of the disease.

L. B. Ashton under regular program reported a case of **Hodgkin's Disease**, and presented specimens of the pathological lesions in the spleen and liver.

The subject was a male, aet. 62, American, single, a pauper, former occupation, printer.

He was an epileptic and so feeble minded that no previous history could be obtained.

When first seen he was much emaciated, not markedly anemic, could walk, but was unable to move the left arm or shoulder; had no subjective symptoms.

On inspection irregular nodular masses were seen to occupy the supra and infra-clavicular fossae on the left side, these growths each being as large as a man's fist. The skin over these was marked by a network of fine injected vessels. The adjacent axillary glands were greatly enlarged and matted together.

There was also a similar tumor situated near the angle of the left side of the jaw, in the parotid area, nearly as large as a hen's egg; the submaxillary glands were free. These growths were all firm to the touch, immovable, adherent to skin and painless.

Two other smaller nodes were found on the same side, one on the outer border of the Pectoralis Major; the other posteriorly, near the inferior angle of the scapula.



They were button shaped, about one inch in diameter and freely movable under the skin.

No other lymphatic involvement could be found at this time, the cervical glands proper being apparently free. Nothing abnormal could be made out as to the size of the spleen or liver by palpation and percussion. No blood count was made.

About two months later another tumor was noticed on the inner aspect of the right thigh, at about its middle, this grew until one month later it was as large as a hen's egg. Numerous other superficial glands had also become enlarged, but not to any considerable size; these being scattered over the thorax, abdomen, in the inguinal regions and dorsum of the penis—no local infection being present to account for the latter groups.

The left shoulder had grown until now it was fully twice the size of the opposite one. The skin over it presented groups of vesicles from which a little serous fluid oozed; but with no tendency to ulceration. The left arm and forearm had become greatly enlarged and brawny down nearly to the wrist, the wrist and hand less so.

The patient's appetite had been good throughout this period, wasting had not advanced perceptibly. The temperature was an unimportant feature in this case.

Swallowing now became difficult; spasmodic cough—from laryngeal pressure—was almost constant; dyspnoea developed which increased rapidly. Death occurred three months after he was first seen.

Necropsy revealed a general involvement of the deep lymphatic system in the trunk.

The capsule of the liver was studded with flat, circular lymphoid nodules, but was otherwise normal in size and consistency.

The spleen contained a rounded mass as large as a hen's egg which displaced the parenchyma inward; the organ was but little enlarged, its surface being regular and normal looking.

The kidneys were also invaded, nodules as large as lima beans being found in the hilum of each.

The retro-peritoneal, mediastinal and bronchial glands were all involved—the latter being massive and matted together. A few pea-sized enlargements were noted under the pericardium along the course of the Coronaries.

The tumors on the shoulder were found, on section, to present an even, firm, suet-like appearance, white in color throughout—corresponding in this exactly to those found in the viscera.

The case proved an interesting one, in that the deep chains of lymphatics were shown to be much more diffusely infected than the superficial ones; while the somewhat atypical location of the original palpable foci, coupled with the age of the patient, absence of the classical bilateral cervical enlargement and the firm fixed character of the tumors on the shoulder and jaw, might at first sight suggest Sarcoma, of osseous origin.

Under regular program for the meeting, F. T. Brenner read a paper on **Optic Nerve Tumors.**

Discussion by W. W. Williams, L. H. A. Nickerson, F. E. Nichols, R. J. Christie, Jr., and J. A. Koch.

The subject of this paper—Optic Nerve Tumors—was not chosen for the purpose of bringing out a detailed discussion, as tumors originating directly within or upon the optic nerve are of such rare occurrence that it is not to be expected that we would be sufficiently interested to devote to it much time or study. So far as I have been able to determine, there are only about seventy recorded cases. Noyes in his text-book says he has never seen a case of this kind.

Among these tumors are included the fibroma, sarcoma, glioma, endothelioma, gumma, tubercle, and myxoma; the great majority being myxoma or myxo-sarcoma. The myxoma frequently shading into the fibrous and sarcomatous forms. The gumma and the tubercle being so rare as to call for only a passing notice. They are nearly always slow growing and painless, even the sarcomas, and 75 per cent. of them occur in early childhood and youth; the exception being the glioma, which is usually found in infancy and is of rapid growth.

In size they have been found from a hazel nut to as large as an egg. The diagnosis is very apt to be obscure, as any growth behind the bulb—whether springing from the nerve, orbit or brain—would produce very much the same symptoms, viz: pushing forward of the globe and impairment of vision.

Two points, however, that speak in favor of the growth being within the nerve are:

First, early defective vision; naturally occurring earlier when the nerve tissue itself is being destroyed than when from pressure against the nerve from without.

Secondly, unaffected motions of the globe. The tumor within the nerve and directly behind the eye ball forms a sort of cup shaped stump upon which the globe can be freely rotated, while an outside growth would wedge itself between the ball and the orbit, crowding the globe in one or the other direction and restricting its movements.

The treatment, of course, is removal of the neoplasm. Eleven cases are on record where this has been accomplished without enucleating the eye, but nothing has been gained as in each instance atrophy and shrinkage of the eye followed. Recurrence is not to be expected as it has occurred in only a few instances.

The case I have to report occurred in the practice of H. M. Harrison, with the following history: Mrs. Marg. Jacobs, sixty-two years old, farmer's wife, mother of four children, and always had very fair health. Two years ago last August, while doing the family washing, she was overcome by the heat. Both eyes felt hot and swollen with considerable smarting. She thought this smarting was due to sweat getting in the eyes. From that time on her right eye caused more or less trouble.

About this time her family physician told her she had diabetes. Two or three months later she noticed a growth bulging the lower conjunctiva. One year later, in July, 1901, Dr. Harrison removed the growth which seemed



to be of a fatty nature. Eight months later, in February, 1902, she noticed a pearly lump again appearing; her sight gradually becoming dimmer. The following September, three months ago, Dr. Harrison dissected out this small tumor—the size of a small hazel nut—which microscopical examination showed to be lipomatous with a few embryonal connective tissue cells scattered through it, causing the suspicion that the growth was something more than a simple lipoma. Up to this time no protrusion of the ball had occurred.

When again seen, December 9th, last, a marked change had taken place, the eye being considerably displaced upward and outward; vision poor, could see only very heavy type. The findings with the ophthalmoscope were a neuro-retinitis and choked disc. General health fair. Urine 1030 and contained considerable sugar. This diabetic condition was noticed two years ago, and as no examination of the urine was made previous to that time and as she has had practically no diabetic symptoms, it is not known how long this condition has existed.

On December 9th, under ether anaesthesia, Dr. Harrison removed the growth; first enucleating the eye, when the tumor—about the size of a walnut—was found completely filling the posterior part of the orbital cavity and the conical end wedged firmly into the orbital foramen. With a curved scissors the entire growth was removed. Recovery uneventful; patient left the Hospital two weeks after operation.

The growth proved to be Myxo-Lipoma, originating from the pial sheath just behind the globe, the main portion gradually extending backward and by its conical form separating the nerve sheaths encapsulating the tumor. The part protruding forward and under the eye ball, the pearly tumor previously removed and one of which you now see attached to the tumor, was of a different structure than the main growth. The small nodules are lipomatous though showing a tendency to myxomatous change; the tumor proper growing from the nerve and the lipomatous nodules from the lymphoid tissue surrounding the eye ball.

John A. Koch, Official Reporter.

**Chicago Gynecological Society** met December 19, 1902, with President, C. S. Bacon in the chair.

Maximilian Herzog presented further sections from the cases of **full time extrauterine pregnancy** reported by F. B. Earle at the last meeting of the Society. At the previous meeting the impression was left that a possibility existed that the one specimen showing muscular tissue might have been the round ligament, or more probably utero-ovarian ligament. In the further sections from the specimens there were much hypertrophied muscle fibres, which precluded the possibility of their derivation from either ligament. Dr. Herzog proved his contention that the hypertrophied muscles were from the gestational sac by presenting numerous sections of extrauterine pregnancy removed by other operators; he held further that in all probability these immensely hypertrophied fibres

were derived from the muscularis of the arteries. J. Clarence Webster thought that from the rhythmic contractions observed in one of Dr. Earle's cases that it might have been a case of cornual or interstitial pregnancy. He still maintained that the specimen shown at the previous meeting was part of the round, or more probably, from the large arteries a section of the utero-ovarian ligament. The muscle fibres in the other specimens do not show more hypertrophy than is usual in the wall of an extra uterine pregnancy.

Rachelle S. Yarros presented a specimen of **pregnancy complicated by tumor, probably fibroid**. Woman, aged 35, multipara, first child was born normally three years ago with severe post partum. Second pregnancy spontaneous with a dead child, and normal puerperium. Had had chorea in this and the previous pregnancy. A tumor was present, but the signs of pregnancy were doubtful; an exploratory operation was done, and revealed a bilobate mass, the larger, right portion proved to be the gestational sac, the left, this tumor. An interesting feature of the specimen was that in the course of the operation it was necessary to remove the pregnancy sac first, and in so doing the cavity was opened: after removal uterine retraction occurred expelling the intact amniotic sac and fetus through the incision. Retraction was so marked that the placenta was partially separated from its site. J. Clarence Webster stated that the retraction of the uterus after operation was an interesting fact, but it was generally known that retraction of the uterus took place after death, or after the uterus was removed in the course of Caesarean Section.

Uterine activity is probably due to the ganglia within the uterus. Dr. DeLee stated he had had a post mortem Caesarean Section in which the uterus retracted normally—as well as it did in life.

T. J. Watkins presented a specimen of **round cell sarcoma of the ovary**; its special interest was the appearance of an early ascites.

M. L. Harris reported a **symphysectomy** on a woman who had had a craniotomy in her first labor, the fetus having died from a prolapse of the cord. She had a generally contracted rachitic pelvis with a marked development of a second promontory. The operation was done by the method first suggested by Dr. Harris, i. e., separating the sub-pubic ligament from the symphysis, thereby preventing undue hemorrhage, and minimizing the danger of injury to the adjacent soft parts in the extraction. Briefly the case presented the following obstetric features: Conjugata vera was 8 centimeters, the false conjugate was 7.5 centimeters. In anticipation of the operation she was prepared surgically. Labor was in progress for 24 hours with no engagement of the head which was in a left position. Pains for 22 hours were at fifteen minute intervals, not strong. At the end of the 24 hours pains were active, and the pubic section was done. The operation was done as follows: An open incision was made over the pubes from its upper border downward, but not to the clitoris—in all about 5 centimeters. With the finger as a means of

protection behind the symphysis the symphysis was opened with an ordinary scalpel, from before backward; with a blunt pointed bistoury the subpubic ligament and deep perineal fascia were separated from the pubic arch on either side; as the fascia was separated alternately on each side the joint opened for about 4 centimeters. Dr. Harris thinks symphyseotomy has a mortality greater than the severity of the operation would warrant. Eliminating cases in *extremis*, mortality is due to two factors—sepsis and hemorrhage. The latter arises from the laceration of erectile tissues and large vessels which are dilated by pregnancy. Infection is increased by the laceration of these tissues. He thinks hemorrhage may be entirely eliminated by his method. In his three cases the patients did not lose more than an ounce of blood. He thinks there should not be any mortality in cases where adequate surgical cleanliness may be secured. The after treatment is simple. After the wound is made it is packed with sterile gauze; when delivery is consummated the bones are pressed together—adhesive strips are carried clear around the pelvis; sand bags are placed on each side of the woman, firmly compressing the hips. The puerperium was without complication, and when she got on her feet at the end of the third week there was only a slight play of the joint as is frequently observed after the lying-in.

H. F. Lewis inquired how the estimation of the size of the baby was made, and if the head had been impacted, would he still operate.

J. B. DeLee thought that symphyseotomy had returned to the obscure position the operation held years ago, and deservedly so. In one of his cases he practiced Harris' method, but the hemorrhage was very severe when the ligamentum arcuatum was separated from the pubes. The case had varicose veins about the pubes which was a bad complication. In another case he got along just as well as with the Harris' method. He believes the danger of joint infection is great; it is near an infected focus, the vagina. In the case reported the consideration of Caesarean Section should have held a place. If doubts had existed as to the asepsis of the patient symphyseotomy should have had consideration over Caesarean Section. In both of his cases of Symphyseotomy the women were delivered through the pelvis, but the children were smaller in each instance.

Dr. Goldspohn inquired if any who had had experience with Caesarean Section had difficulty with uterine inertia in debilitated patients. He had done a symphyseotomy on an exhausted patient once. In a like case he would only do the Porro operation if an abdominal operation were done. His case was one where repeated attempts had been made to induce premature labor, in the course of a 72 hours labor, had had five anesthetics, forceps applied three times, in which endeavors to extract strong men were tired out temperature was 102, pulse 150, and the lower abdomen disfigured with edema. Afterward it was necessary to hold the uterus bimanually to prevent bleeding from inertia. The patient recovered but the child died at the

end of three hours, the result of a rupture of the longitudinal sinus from the forcep attempts.

H. Banga cited a recent contribution by Gigli who advised cutting the pubes, thus avoiding the danger of joint infection.

Rudolph W. Holmes mentioned that Caesarean Section should always be an elective, primary operation; in cases where version, forceps, etc., have been tried, and failed, then a Caesarean done successfully with a living mother and child, it is more good luck than anything else that such result obtains. American operators do not realize this sufficiently—they do not realize that a woman who has been examined vaginally repeatedly, and perhaps by unclean hands, is essentially septic and may die from infection as a result of a Caesarean operation. European operators recognize this fully on relative indications they will not do a Caesarean Section where outside hands have examined through the vagina in labor. He thinks it is a fair presentation of the outline for placing indications for Caesarean Section and symphyseotomy as follows; in pregnancy, or early in the first stage, one should choose Caesarean Section, if the woman is distinctly not septic—no internal examinations having been made, or at least that such internal examinations were accompanied by all the antiseptic details incident to vaginal abdominal work,—and that the mother and child are in good condition. Symphyseotomy should only be considered in the second stage when descent of the head fails to occur on account of the bony obstruction, and of course the baby and mother must be in good condition. Symphyseotomy never will have a permanent place in obstetrics until cephalometry is so developed that one may accurately learn the relative sizes of fetus and pelvis. The too frequent reports of symphyseotomy followed by craniotomy are evidences of the difficulties in discerning the relative sizes of pelvis and fetus. As an elective primary operation symphyseotomy offers no inducements over Caesarean Section, in fact as the maternal mortalities are the same, and the fetal full three times higher for the former than the latter the latter should be the operation of election.

Dr. Harris (in closing). Believes there is one argument in favor of symphyseotomy which was alluded to by Dr. DeLee, namely, that subsequent labors may terminate spontaneously or at least without a major operation, due to the increased physiologic pubic separation. He claimed Dr. DeLee's case of hemorrhage was due to not hugging the bone in separating the ligaments. Dr. Harris claimed the danger of joint infection after symphyseotomy bore no relation to joint infections elsewhere, for the danger was due generally to inability to drain properly. In the pubic joint drainage was easily secured. Finally he claims that Caesarean Section is a more dangerous operation than symphyseotomy.

J. B. DeLee read a paper entitled **Report of 3 Cases of Rupture of the Uterus During Labor.** He reports three cases, and makes deductions from a study of 7 others. One must clearly differentiate between complete and incomplete ruptures, the mortality from the former is great,



of the latter rather good. The appropriate treatment for incomplete rupture is to deliver and tampon uterus and rent. If tamponade does not stop hemorrhage, then the abdomen must be opened. Complete rupture requires one of the following methods of treatment::

1. Deliver placenta and child from below; expectancy, ice bag, ergot, opium, i. e., symptomatic treatment.

2. Deliver child from below, sewing up rent as much as possible, rent and uterus, tampon, then as No. 1.

3. Deliver child from below, sewing up as much of the rent as possible, and tamponade of the remainder.

4. Vaginal delivery, vaginal hysterectomy.

5. Laparotomy, remove child, etc., Suture of uterus.

6. Laparotomy, removal of fetus, etc., Partial or complete extirpation of uterus.

Palmer Findley had charge of one of the cases after Dr. DeLee had delivered her, and sent her to the Presbyterian Hospital. He gave an instructive outline of the expectant treatment practiced with eventual recovery.

J. Clarence Webster, stated that all the cases of rupture of the uterus in which the rupture was extensive, and either a complete or partial escape of the fetus into the peritoneal cavity, had died of sepsis or hemorrhage. His cases had almost entirely come from midwives' hands.

F. E. Pierce reported a case in an European clinic, in which a complete rupture had occurred, she was transported by train to the city, had a laparotomy, child removed from the abdomen, and she eventually recovered.

Rudolph Wieser Holmes, Official Reporter.

The Chicago Electro-Medical Society held its 17th regular meeting in room 912, Masonic Temple, Monday, December 29, at 8 P. M.; the president, Elmore S. Pettyjohn, in the chair. Minutes of the last meeting were read and approved.

Pursuant to notice given at the last regular meeting the constitution was amended and by the addition of an assistant secretary and an assistant treasurer to the list of officers, and a scientific research committee to the list of standing committees.

The following new members were elected: T. S. Middleton, W. T. Stewart, H. J. Stewart and Gustavus M. Blech, and Edward W. Carr an associate.

T. S. Middleton read a paper on **The Therapeutic Value of Vibratory Electric Currents.**

Old ideas and old methods are continually changing. Where formerly bleeding and depletion were almost universal we now find remedies of an exceedingly mild type in common use. It is so with electricity. Instead of torturing and burning the patient by shocks and heavy currents we now seek to attain and do attain much better results with exceedingly mild currents. I have been able to obtain results little short of the marvelous by using a vibratory current from the static machine when the disks are making only 20 revolutions per minute, with a current so mild that it would to many opera-

tors seem perfectly useless. My greatest success has been in acute and chronic nervous troubles, neuralgias, paralysis, tic douloureux, rheumatism, fibroids, etc. In treating I use my two hands as one electrode, grounding one pole and having the other connected with the insulated platform upon which the patient is seated.

H. P. Pratt remarked that a fibroid can be disintegrated by Apostoli's method or by the X-ray, but that the current described by Dr. Middleton was entirely too weak to accomplish this result. This method was first described by Dr. Morton in 1881 and has since been superseded by the hyper-static machine.

P. S. Replogle said that if he could do as much as Dr. Middleton claimed to do he would quit the practice of medicine and surgery and take up electricity alone.

O. W. McMichael expressed the same opinion.

Dr. Pettyjohn agreed with some of the statements made by the speaker. Regulation of the generator is important. It is advisable always to use mild currents, and the vibratory currents described by the speaker stimulate metabolism. Static machines are useful, but he had never found them to act twice exactly in the same manner.

Dr. Middleton admitted that the method was not new, but claimed that it was more efficient and less dangerous than any other known method and required much smaller apparatus. He had had constructed a static machine small enough to carry around in his hand, which was driven by a spring motor and which gave excellent results. He was accustomed to keep his machine in good working order by means of an electric fan which kept the machine clear of ozone. He invited those who doubted his results to come to his office and see for themselves.

T. P. Hall read a paper describing an improved fluoroscope which he exhibited to the members present.

T. P. Hall, Official Reporter.

The Chicago Surgical Society met January 5, 1903, President John B. Murphy in the chair.

Arthur Dean Bevan presented a paper on **The Surgical Treatment of Anuria**, and detailed the history of a case of anuria recently operated upon, with satisfactory result.

Total suppression of the urine occurs:

1. From mechanical obstruction of the ureter of the single functioning kidney of an individual, the other kidney either being congenitally absent or destroyed by previous disease.

2. From mechanical obstruction of one ureter in an individual possessing two functioning kidneys, with increased intrarenal pressure on the obstructed side, which by reflex nerve action prevents the unobstructed kidney from functioning, the so-called reflex anuria, or, possibly, after a nephrectomy, the involvement of the nerves in the pedicle may produce a reflex anuria.

3. From trauma of both kidneys, which, for a time, or until a fatal issue, is followed by complete cessation of function; also from trauma of a single kidney which apparently



by reflex action so affects the uninjured kidney that complete anuria results.

4. From acute nephritis, as sometimes seen in scarlet fever and other forms of septicemia.

5. From certain poisons, as phosphorus, lead and turpentine, ether, chloroform, etc.

6. From the peculiar condition known as urethral fever, commonly the result of the passage of a catheter or sound.

7. In the polymorphous symptom-complex, known as hysteria, anuria may occur.

The author stated that anuria is a condition, not a disease, *per se*, and until the last ten years the condition has been discussed merely as a symptom occurring in a number of diseases, which usually marked a fatal termination, and for which little could be done by the medical attendant. Within the last twenty years, however, so much light has been thrown on the subject by Tuffier, Morris, Nael, and others, and so much good has been accomplished by intelligent surgical interference, that today the condition of anuria is entitled to be placed in the same class as the condition ileus, as one of sufficient importance to be considered and handled as a surgical entity.

After citing briefly several cases gleaned from medical literature, the author presented a classification, namely, first, obstructive; second, reflex or paralytic; and third, non-obstructive or nephritic anuria.

From a careful study of the literature and of his own case, the essayist reached the following conclusions:

1. The clinical importance of recognizing the three forms of anuria-obstructive, reflex, and non-obstructive.

2. The imperative necessity of surgical interference in the obstructive and reflex forms, and its possible value in the non-obstructive cases.

3. That in the first two varieties a rapid nephrotomy on the side of pain, tenderness and muscular rigidity is the operation of choice. If necessary, do not hesitate to make a double nephrotomy.

4. That nitrous oxide anesthesia is probably to be preferred.

5. That time-consuming operations to relieve permanently the obstruction are to be postponed to a later period, after the patient has recovered from the anuria.

6. Operate by the beginning of the third day.

M. L. Harris, in opening the discussion on Dr. Bevan's paper, said that one of the most important points in connection with the surgical treatment of anuria was the diagnosis. In classifying the different forms of anuria, he suggested as subdivisions primary and secondary anuria.

E. Wyllys Andrews remarked that the paper was helpful on account of its suggestiveness. The indications for operative or other treatment should be precise. He thought catheterization of the ureters would clear up some of these cases, and that it would not be necessary to resort to operative intervention.

D. S. Fairchild, of Clinton, Iowa, reported a case in which the pathological condition of the right kidney came on suddenly. It was

thought the patient was suffering from uremia. An incision was made in the lumbar region and the kidney felt much enlarged. The kidney was freely incised, but no abscess was found. A suppurative nephritis was going on, as indicated by the appearance of some pus on the dressings. The patient had anuria for some days. The day following the operation patient passed some urine from the other kidney, and in three or four days the quantity of urine secreted became nearly normal. Patient was making a good recovery.

William Jepson, of Sioux City, Iowa, reported an interesting case of multiple cystic right kidney, the size of the cysts being the size of cysts of the ovary. The other kidney was let alone. Several days after the operation the patient developed symptoms of uremia, and died the ninth day after operative intervention.

L. L. McArthur stated if only a few drops of urine escaped the differential diagnosis was far more difficult, because the surgeon might not be sure he had an obstruction to deal with, and might believe that the trouble was due to the poor functioning capacity, without obstruction, when it might prove to be a partial or almost complete anuria, as in a case that came under his observation.

Thomas A. Davis called attention to some experiments that had been made and published recently in the American Journal of the Medical Sciences. The caliber of the renal veins was arrested in their lumina for the purpose of causing passive congestion of the kidney, but without lessening the amount of urinary secretion. The author of the experiments concluded that nephrotomy to establish the circulation, provided the venous circulation be relieved, would not lead to an increase in urinary secretion, and that this operation was not indicated.

Dr. Bevan, in closing the discussion, in reply to the remarks of Dr. Andrews, stated that Israel had gone over the matter of catheterizing the ureters in cases of anuria, but had come to the conclusion that it was of little or no value, and that surgeons should resort to nephrotomy.

Emanuel J. Senn read a paper on

#### THE TRANSPLANTATION OF OMENTUM IN THE OPERATIVE TREATMENT OF INTESTINAL DEFECTS; A CLINICAL AND EXPERIMENTAL CONTRIBUTION.

The omentum plays a great role in the reparative process following traumatic injuries of the abdominal cavity, both in the destruction of microbes and protection of the general peritoneal cavity by reason of adhesions with intestines and the parietal peritoneum. While omentum transplantation is a recognized operation, as a re-enforcement of intestinal suture, the author was impressed with the possibility of the use of omentum for directly covering an intestinal defect. Such a pathological condition following a duodenal ulcer, intestinal tuberculosis, gangrenous cecum, the result of an appendicitis, where enterorrhaphy cannot be resorted to, by reason of the unreliability of the surrounding tissues in withstanding ten-

slon, or where suturing would cause too great narrowing of the intestinal lumen; also where the condition of the patient or extensive adhesions would not permit an enterectomy. The omentum has been transplanted over perforations in the stomach, both in experimental work and in man.

The essayist, after referring to the work of Bennett, Braun, Tietze, Enderlin, and others, reported a series of experiments for the purpose of investigating the possibilities of omental transplantation. The experiments were done under the most favorable circumstances as regards the surroundings for doing aseptic work, but the results were unfavorable. The author stated, however, that the unfavorable results from the experiments are no criterion of the future value of omental transplantation. The omentum in the dog is thinner than in man, and the adipose tissue is not as abundant nor as vascular; therefore, not as favorable for plastic work. The stomach is apparently the most favorable portion of the alimentary tract for omental transplantation. By reason of its fixed position, the gastric movements do not place as much tension on the transplanted omentum as is the case with the peristaltic wave of the intestines. The great omentum in this region is also found near its attachment, which may also be a favorable factor. The experimental and clinical evidence is abundant proof of this fact. The cecum is the most favorable portion of the intestinal tract by reason of its slight mobility. It lies in one of the regions most frequently attacked by pathological processes, and the future will demonstrate the adaptability of omentum for defects which cannot be closed by suture. Resection of the cecum or a lateral anastomosis is a formidable operation, as compared with omental transplantation. Primary transplantation of the omentum in gangrenous appendicitis will greatly obviate fecal fistula, which so often follows the operation. Until more clinical evidence accumulates, showing that reliable suturing can be done, intestinal transplantation of omentum should not be resorted to unless there is abundant drainage down to the seat of suture, besides walling off the general peritoneal cavity.

The author concludes:

1. Transplantation of omentum over defects in the stomach is an established operation.
2. Transplantation of omentum over intestinal defects is recommended, but is still in the developmental stage.
3. Transplantation of omentum over defects in the cecum is the most favorable portion of the intestinal tract.
4. Transplantation of omentum over defects in the small intestine should only be done after fixation of the segment of the intestine to the abdominal wall.
5. Gauze drainage should be resorted to, excluding the general peritoneal cavity.

E. Wylls Andrews said the conclusions arrived at by Dr. Senn were those which others had reached in the course of experiments upon animals, and also from experience in operating.

Daniel N. Eisendrath said he believed that the reason for the apparent failure in the experiments on animals was, as the essayist had said, namely, a difference in the construction of the omentum in the human being and in the dog.

Jacob Frank remarked that the omentum of the young dog was very thin, the same as it was in young children, while the omentum of an old dog was much thicker, and corresponded to that of adults.

Arthur Dean Bevan could see the value of omental grafting in lesions of the stomach, but doubted its value in lesions of the small intestines and of the colon, with the exception of the transverse colon. Probably the most common cause of intestinal obstruction was adhesion from the omentum in which the omentum was involved. If one used the omentum in a lesion of the ileum, there was great danger of subsequent ileus.

Dr. Senn, in closing the discussion, said it was seldom a surgeon was called upon to use the omentum for intestinal fistula outside of the work of appendicitis.

Arthur Dean Bevan exhibited a **carcinomatous larynx** which he had removed about five weeks ago by the Keen method, a method which he had employed in a previous case. The patient recovered, with complete closure of the pharynx, within three weeks after the operation.

Albert E. Halstead, Official Reporter.

The McLean County Medical Society held its regular meeting January 8th.

The paper of the evening was read by W. R. Shinn, of Chenoa, on "**Insanity of Pregnancy**." The paper showed that he had studied the subject thoroughly and elicited thorough discussion by those present.

The Committee on Law called attention to the fact that the Committee on State Legislation had made a call for financial help from members of the profession and urged all to respond. They also introduced a resolution which was adopted, that the **Society and profession petition Representative Hon. Wesley M. Owen of this district to support the Medical Practice Act introduced at this session.**

A committee was appointed to canvas the local members to ascertain if it is their desire to have the State Medical Society meet in Bloomington in 1904. There is a general feeling that Bloomington should get this meeting as the State Society has not met here for thirteen years, and with our new hotel facilities we are well able to entertain this noted body.

The society has been offered space in the Public Library for medical books that will be contributed from time to time by the profession or their families. This is a source of gratification and a number signified their intention to contribute.

H. L. Henline, of Colfax, Edson B. Hart and S. L. Stevens were admitted to membership.

The death of Nesbit F. Jordan, a member, was announced. Dr. Jordan died December 28,



1902, of typhoid fever, age 38 years. He was a graduate of the Ohio Medical College, of 1884, and had practiced in Bloomington since 1887. He was a man of high professional ability and great personal worth.

The committee, consisting of A. F. Kaeser, chairman, J. K. P. Hawks and Edson B. Hart and R. A. Noble, which was appointed at a former meeting to look up the record of typhoid fever cases in Bloomington and Normal for the last year, made its report as follows:

Number of cases, 130.

Number of cases using city water only, 18.  
Infection traced to well water, 73; Chicago water, 3; milk, 1; caring for typhoid patients, 3; contaminated food, 9; unknown, 41.

Families more than one case—Nine families, 2 cases; 4 families, 3 cases; 1 family, 4 cases; 1 family, 6 cases.

It will be seen that about one-half of the number of cases have been caused by the use of well water. Eighteen cases have used only city water, but in all these it has been the opinion of the attending physicians that the infection was due to other causes, and they think that not a single case of typhoid was caused by the use of the city water, which opinion agrees with the statement of Prof. R. O. Graham, that the city water has been as good during the past five years as at any time.

E. S. Reedy, Official Reporter.

The Chicago Laryngological and Climatological Association held a regular meeting in the Schiller Building, November 24, 1902, with Norval H. Pierce in the chair.

A. H. Andrews reported

#### **A CASE OF EXTENSIVE NECROSIS OF THE TEMPORAL BONE WITH INVOLVEMENT OF THE SEMICIRCULAR CANALS AND DESTRUCTION OF THE FACIAL NERVE.**

Extensive necrosis of the temporal bone while not infrequent is always of great interest. Tuberculosis and syphilis are the usually assigned causes for these cases. Sometimes the cause is easily discovered and sometimes there is more or less obscurity in the etiology. Destruction of the temporal bone may be rapid in progress with great pain and constitutional disturbance. It may be slow in progress without pain and but little constitutional disturbance. The extension of the destructive process may lead to perforation of the mastoid over the lateral sinus or into the middle fossa, or it may attack the deeper structures involving the internal ear. It is never easy and sometimes is impossible to determine the extent of the destructive process until the parts are exposed, either by operation or autopsy. Facial paralysis, total deafness and the detection of necrotic bone at the bottom of the auditory canal always point toward destruction of the deeper parts of the temporal bone, but even with these symptoms, an operation may reveal only a small amount of diseased bone. However, with only these three symptoms present, I have in two cases found almost the entire petrous portion of the temporal bone necrotic. In one case, I removed

a sequestrum which contained the internal ear and internal auditory canal. In the other case, I found the sequestrum containing practically the entire labyrinth, after removing which, I cleared away pus and granulations from the internal auditory meatus. It was the latter case which I desired to present tonight, but being unable to secure the presence of the patient, I have selected another which belongs to the same class and is present for examination.

The patient, C. K., baker, age 29. Family history good. No evidence of pulmonary tuberculosis, and no obtainable history of syphilis. In 1898 the patient noticed impairment of hearing in both ears, which gradually increased. In the fall of 1900, two years later, a discharge began from the right ear. No pain preceded the discharge, nor has there been pain in the ear at any time since. The discharge was slight in the beginning, but gradually increased in amount. After the discharge had continued six months, the patient noticed that one side of his face was partially paralyzed. In three days the paralysis was as complete as it is now. About the same time the patient began to have attacks of pain in the stomach and bowels. The paroxysms would last two or three minutes and would recur several times during the day. The attacks of stomach trouble would last for a day or two and then disappear for a few days or weeks. About this time the patient consulted a physician who curetted the middle ear or auditory canal. The patient cannot give a definite history of this operation.

I first saw the patient in October, 1901. At that time he came to Dr. Turk's clinic at the Post Graduate for the trouble with his stomach. Dr. Turk sent him to me to have the ear examined. I found a profuse discharge from the ear. A probe revealed the presence of dead bone in the auditory canal. The canal was swollen so that the middle ear could not be examined. There was no tenderness about the ear nor swelling over the mastoid. Complete right facial paralysis was present. Hearing in the right ear seemed to be entirely obliterated. Temperature ranged from 99° to 101°. Pulse was slightly accelerated. An operation was advised, and on October 19th the patient came to the Post Graduate Hospital. The usual post auricular incision was made and the external table of the mastoid process removed with a chisel. The mastoid process was filled with pus and granulations, and the posterior part of the auditory canal was denuded and the bone necrotic. In removing the necrotic bone with gouge and curette, the horizontal semi-circular canal was opened. Following the canal forward, we came upon the vestibule which was filled with granulation tissue. The external wall of the vestibule was removed, and the mass when taken out was found to be a complete cast of the vestibule having projections upon it corresponding to the oval window, the round window and the ampullae of the semicircular canals. Remains of the facial canal were found in the necrotic bone. This canal was traced forward to its angular turn



opposite the hiatus Falloppii and was followed out ward to the stylo-mastoid foramen. No trace of the facial nerve could be found. An attempt was made to remove all the diseased part of the temporal bone with apparent success. The auditory canal was enlarged by making two incisions, one in the upper, the other in the lower part, each extending well into the concha. The tongue shaped flap made by these two incisions was stitched back to the margin of the post auricular incision, which was closed completely with interrupted sutures. The wound was packed with iodoform gauze through the enlarged meatus; the usual dressing was applied and the patient put to bed.

Immediately following the operation, the temperature and pulse became normal, and the stomach trouble of which the patient complained of disappeared entirely. The patient left the hospital ten days after the operation, but continued to come to the clinic for dressings.

The post auricular wound healed by first intention, and most of the wall of the operation cavity became lined with epithelium. The discharge at no time entirely disappeared. A few months after this operation, a small amount of dead bone was discovered high up in the cavity. April 23d of the present year, a second operation was performed, and this dead bone thoroughly removed. Following the operation this part of the wound soon became smooth and covered with epithelium. A few weeks later another area of necrosis was found external to the first. This bone has been curetted under local anesthesia, but evidently not all of the diseased portion was removed. The pus and granulation have been repeatedly examined but at no time have bacilli other than the staphylococcus been found.

**Present conditions:** Exposed bone can be detected in the upper part of the cavity. A small amount of discharge comes from this area. The patient's general health is apparently good, although his strength is not yet what it was before the ear trouble began. There is complete paralysis of all the muscles supplied by the facial nerve. The eyes are noticed to involuntarily turn to the right when the patient winks, or closes the eyelids. Extensive changes have taken place in the pharynx, but the patient denies ever having had sore throat, except at one time, when under my care, he suffered from an apparently simply pharyngitis. The patient still has some hearing in that ear, although not sufficient to be of any value. A number of interesting points arise in connection with this case. 1st There has been at no time pain in the ear. 2d. Although the semicircular canals have been diseased there has been no tendency toward dizziness at any time. 3d. The question of etiology is still unsettled. 4th. The apparent relation between the destructive process in the ear and the paroxysms of pain in the stomach and bowels. 5th. While there was no possibility of anything being done to relieve the facial paralysis, in this case, the question naturally arises as to whether anything can be done

to restore the function of the facial nerve when but a small portion of it has been destroyed.

#### Discussion.

**J. Holinger:** I would like to take exception to one remark made by the essayist, namely, that these cases of extensive necrosis of the temporal bone or osseous labyrinth are either tubercular or syphilitic. As a rule, they are neither, but we have a process which is similar to osteomyelitis in other parts of the body, as, for example, the shin bone. Bezold has pretty well established this fact, and has proved that there are two forms of tuberculosis of the ear. In one form, connected with a comparatively good general condition of the patient, there are several small perforations at the posterior margin of the drumhead. This form of tuberculosis shows scant bacilli in the secretions. The other form of tuberculosis of the temporal bone occurs in old tubercular patients in the very last stages of tuberculosis of the lungs, and this form is characterized by a rapid breaking-down of all of the tissues of the ear and the surrounding parts. This extensive necrosis is due to lack of resistance and regeneration against infection by the staphylococci or streptococci, and very often pneumococci.

In cases as Dr. A showed, while the whole wound is granulating, we have to institute a therapy which is similar to that made use of in cases of very old necrosis, in osteomyelitis. An aim must be to establish a good epidermis. For this purpose, I have found a salve of one-half per cent of nitrate of silver of great value. Later on, after two or three days, I use dusting powders of different kinds. Lately, I used vioform with better effect than any other agent. I would suggest this form of treatment if there is no more necrosed bone to be removed.

**G. P. Head:** It would seem to me, from the appearance of this case, after examining it, that the disease is of specific origin. At any rate, the case is highly suggestive of syphilitic disease.

**Frederick Menge:** I saw a case similar to this a short time ago, the necrosis of the temporal bone resulting after an operation for carcinoma in that region, and so it must not be forgotten that this condition may be the result of an operation at the time.

**George E. Shambaugh:** This case presents several points of interest. In the first place, from the history given, it appears to be one where the trouble in the ear began primarily in the bone itself, whereas usually the bone becomes affected secondarily to middle ear disease. The appearance of the lesion in the pharynx leaves scarcely a doubt that the trouble there is the result of syphilis, and the same disease has probably caused the trouble in the temporal bone. The granulation mass which the doctor removed from the vestibule, having, as he says, a prolongation which extended through the oval window, and another which protruded through the round window, shows that the bone necrosis involved not alone the vestibule, but that there must have been

a more or less extensive involvement of cochlea as well, for the round window does not communicate directly with the vestibule, but opens into the scala tympani of the cochlea. In order for the granulation mass in the vestibule to reach the round window there must be considerable involvement of the cochlea, since the mass must first break through the lamina spiralis separating the scala vestibule from the scala tympani.

Another interesting question in connection with this case has to do with the ability of the patient to hear with the affected ear. When necrosis has invaded the cochlea as in this case, I question whether it is possible for the ear to retain any hearing power whatever, for a necrosis in any part of the cochlea almost always results in absolute deafness as far as that ear is concerned. The doctor states that the patient was still able to hear a little in the affected ear. He has not stated what tests he used to arrive at that conclusion. I simply wish to say in this connection that when there is such a marked degree of deafness and when it is a question whether there exists total unilateral deafness, or whether there is still a remnant of hearing left in the affected ear, we have to deal with one of the most difficult problems in all the functional tests. When both ears are involved, the diagnosis of total deafness is a simple matter, but when one ear alone is involved, it is a much more difficult problem. The bone conduction tests can be of no value, since the tones are heard by the other ear. The Weber will be lateralized in the better ear, the Rinne will be absolutely negative, while the Schwabach at whatever point the fork is placed will be heard by the better ear. In the tests for air conduction, it is easy by using the Dennert control to establish the diagnosis for the voice and for forks below C, but for all tones above C the Dennert control cannot be relied upon, because these tones cannot be shut out from the normal hearing ear.

The only positive method for establishing the diagnosis of total unilateral deafness for tones above C is by the method used by Bezold. This is a method of comparison using as a type the results of the tests obtained in a case where there can be no question as to the existence of total unilateral deafness, on account of extensive necrosis of the temporal bone in which the cochlea has been thrown off in a sequestrum.

**Dr. Andrews** (closing the discussion): With regard to the tests which I made to establish the fact the patient hears, I think they are perfectly clear. As to the tests mentioned by Dr. Shambaugh, I would say, it is much more difficult to prove that the patient does not hear than to establish the fact that he does hear. I admit that it is exceedingly difficult to prove that there is no hearing in one ear when the other ear is normal or nearly so. But it is usually not difficult to determine that the patient does have hearing in one ear, especially if the opposite ear is seriously impaired. In this particular case, the vibrating tuning fork was passed back and forth in front of the patient's diseased ear, and he was in-

structed to raise his hand the moment the fork passed close to his ear and he heard the sound. With the patient's eyes covered, I carried the fork more than half way around his head, and he paid no attention to it, but the moment it was brought close to his ear, the hand was raised. I used a C<sup>2</sup> fork which had strong vibrations.

Regarding the etiology of such cases in general, I assume no responsibility for the statement which I made, but remarked that the usually assigned cause was either syphilis or tuberculosis. I am inclined to think with Dr. Head that even though there is no obtainable history of specific disease, it is a case for mixed treatment. He has been having the iodides, but so far he has not been able to tolerate the dose which I think he should have.

#### Papilloma.

**G. P. Head:** H. H. S., male, age 44. In December, 1900, patient came for treatment. Found a papillomatous growth about the size of a large pea at the sulcus between cheek and jaw on left side in region of last molar. This yielded completely to applications of chromic acid in three or four weeks. There was present a patch of leucoplakia buccalis about  $\frac{1}{2}$  inch below the papilloma. This did not yield to any applications.

In July, 1902, patient returned with a very large papillomatous growth occupying the alveolar edge of the left half of the upper jaw and passing over at the sulcus on the buccal membrane. Had had two molars extracted, each bringing with it a piece of the alveolar process and making an opening into the antrum. The tooth sockets were filled with the growth which did not at the time appear to involve the antrum. A good sized piece of the tissue was submitted to the Columbus Medical Laboratory and pronounced simple papilloma. The growth was curetted from time to time, but speedy recurrence took place each time; it spread to some extent beneath the mucous membrane of the hard palate, but has not recurred there since curetting it away. The daily application by the patient of a solution of salicylic acid 30 grains, absolute alcohol 1 oz., seemed for a time to reduce the size of the growth markedly and to be getting it under control.

Recently, however, increase has occurred in spite of the solution, the antrum became involved and curettement secured some of the new growth from that cavity. The alveolar opening into the antrum has steadily increased in size until now a small finger can be readily introduced. The jaw has recently become swollen and painful on several occasions, but this has usually subsided in a few days. There is no palpable enlargement of the glands of the neck. History of the patient negative, Pot. iodid. in small doses—10 grams t. i. d.—has had no effect, nor have small doses of Fowler's sol. (2 minims t. i. d.) for 60 days had any result. The nasal antral opening has never been occluded. The growth as you observe it this evening has the appearance of a papilloma, but its history and present condition are very suggestive of carcinoma, and



I have brought the patient here to secure an expression of opinion from you in regard to its nature.

**J. Holinger:** There is hardly any question but what the condition in this case is malignant. The clinical appearance of the case should be considered of more importance than the single microscopical examination. Papilloma is a disease of the mucous membrane, and anything that is below the mucous membrane, especially in the periosteum, cannot be considered papilloma any more than the explanation we have of this case. It would seem to me from the evidence that the condition is malignant, that is, it is progressing below the mucous membrane, either in the periosteum or bone. Furthermore, the cause of the disease is very much against papilloma.

Otto T. Freer presented a paper on  
**TUBERCULOSIS OF THE LARYNX AND ASPIRATION TUBERCULOSIS OF THE LUNGS FOLLOWING DERMATITIS BLASTOMYCETES.**

The author referred to the infrequency with which tuberculosis follows cutaneous blastomycosis, but four cases in thirty-four being reported to date, including the case presented. Blastomycosis, or infection with pathogenic yeast fungi, is now a well established disease entity, chiefly owing to the efforts of American dermatologists.

The patient's cutaneous affection began two years and two months before the throat symptoms appeared. The skin lesion developed from a small spot to an area of the size of a child's hand, including the left meatus auditorius externus and parts in front of the concha as far as the orbit. The ulcerated surface was raised and covered with spongy granulations and scabs. It nearly healed under treatment with potassium iodide, returned and almost healed again when the same treatment was resumed. The cutaneous affection was diagnosed dermatitis blastomycetes by Frank Hugh Montgomery by means of histologic examinations of tissue and cultures. Tubercle bacilli were not found. The rapid healing under potassium iodide, characteristic of blastomycosis, confirmed the diagnosis.

The patient's larynx, within four and one-half months time had become invaded by an ulceration which totally destroyed the epiglottis and invaded the arytaenoid bodies, false cords and lateral left wall of the pharynx. Histologic examination of excised pieces showed the morbid process to be tubercular, with unusual invasion of the tissues by tubercle bacilli in great numbers.

The loss of the epiglottis and rigidity of the glottis with fixed abduction of the cords left the trachea unprotected against the entrance of foreign matter, and food, fluids and pus from the ulcer, laden with bacilli, readily entered it. Though the grosser masses were coughed out, finer particles were aspirated into the fine bronchi and bronchioles and the tubercle bacilli here caused tubercular bronchitis and peribronchitis, with thickly sown nodular foci of tubercular tissue throughout both lungs,

which were too small to cause marked physical signs, but which gave rise to fever, rapidly increasing weakness and a constant sense of suffocation. The patient died a few weeks after the pulmonary involvement became manifest.

The postmortem examination was performed by Dr. Le Count. It showed the lung affection to be secondary to that of the larynx and that the lungs had become invaded by the form of tuberculosis called aspiration tuberculosis, with the pathological characteristics mentioned. Microtome sections in series showed the spread of the tubercular process from the lumen of the bronchioles through their walls into the surrounding tissues, while the intact condition of the blood vessels added proof that the lung infection was pneumatogenic and not haematogenic.

Dr. Freer called attention to the aspiration method of lung infection in cases of laryngeal tuberculosis with ulcers discharging pus containing tubercle bacilli and thought that this method of the dissemination of tuberculosis in the lungs was not generally appreciated. The type of consumption originating in this way is usually virulent, rapid in its course and accompanied by high fever.

**Frank H. Montgomery:** Dr. Freer and Dr. Rhodes have suggested that I say something in connection with the paper of Dr. Freer regarding dermatitis blastomycetes. This disease was recognized about six years ago by Busse, of Berlin, and Gilchrist, of Baltimore, at about the same time. Since the reports of cases of this disease by those gentlemen, many others have been reported by dermatologists in various parts of the country. Some thirty-two cases have been gathered from the literature, including those that have occurred in the practice of Dr. Hyde and myself. Several cases have occurred in the West comparatively recently, so that the number is constantly increasing. The disease has a very distinct entity.

In the Journal of the American Medical Association for June 7, 1902, I published a brief review of the disease in all of its phases, including a resume of thirteen cases that had come under the observation of Dr. Hyde and myself, the majority of which have been previously published. This article was liberally illustrated, and it occurred to me that it would perhaps be better to pass these illustrations around than to take time to describe the disease to you.

Clinically the disease very closely resembles cutaneous tuberculosis. But the symptoms are different.

The diagnosis can be established or aided very materially by cultures, which can be readily obtained, if the peculiar features of the disease are understood. There are very minute abscesses, so small that they are not visible to the naked eye, but can be seen with a magnifying glass. If the surface is thoroughly cleaned and a culture taken from these deep abscesses, pure cultures are readily obtained. As a rule, the organism is not found on mucous membrane. That has been demonstrated, but we find it in the secretions or fragments from



the ulcers and in fresh preparations. In two out of thirteen cases that have been studied carefully, tuberculosis has been found. In others tuberculosis has been suspected, but careful search has demonstrated that the relation of the tuberculosis to blastomycosis is purely incidental.

**Dr. Freer** (closing the discussion): Dr. Montgomery has earned the society's gratitude by addressing it upon the very interesting subject of blastomycosis. Histologically the disease resembles tuberculosis on account of the many giant cells found in the tissues and because of the miliary leucocytic collections. The differentiation of the two affections is only possible by means of painstaking microscopic investigation such as that of Dr. Montgomery. By means of this the yeast organism may be demonstrated within or surrounding the giant cells.

J. Holinger reported a case of

#### **PAIN OVER THE MASTOID PROCESS, WITH HERPES ZOSTER.**

Mr. K., 48 years of age. The question was whether the mastoid process of this patient should be operated on right away, or whether it was safe to wait. I found the patient rather nervous, which I was told was his usual condition. About six weeks previous to my visit he became ill with a skin eruption which I shall describe presently. He then had very severe pain in the left ear, and especially over the left mastoid process. A week previous to my visit his wife noticed an asymmetry of his face, which increased until he had a complete paralysis of the muscles supplied by the facial nerve of the left side. He never noticed any discharge from the ear.

Examination showed that the skin disease had spread over the left half of the head, neck and chest, to about the height of the mamma. All the different stages can be seen from a red spot to a little pustule, and red rings with the covering of the pustule as a scab lying on it. As a whole, the impression was that the condition was improving. There was some swelling over the mastoid, but it was hard to discover any. The pain is constant, and not increased on pressure. The drum-head and the deeper part of the external meatus showed no signs of inflammation. They looked exactly the same as on the other side. With the catheter, the Eustachian tube was found to be free, especially no bubbling could be heard. The hearing in both ears was the same, seven inches for a whisper. My answer to the question was, therefore, that there is no indication for operation, because the pain in the ear and the mastoid was explained as pertaining to the herpes zoster, which must be recognized. The paralysis of the left facial nerve springs from the same source as the herpes zoster, namely, from the patient's general nervousness. An operation would not only have been of no benefit, but on account of his highly nervous condition it would have produced much damage.

#### **E. Fletcher Ingals reported a case of HYPERAESTHETIC RHINITIS WITH ANGIO-NEUROTIC EDEMA.**

**Case 1.** This was an aggravated case of hyperaesthetic rhinitis with angioneurotic edema practically cured by protracted use of the products of the adrenal gland. Mrs. D. F. J., 39 years of age, came to me in May, 1900, complaining of frequent attacks of obstruction of the naris with excessive watery discharge and great pain in the nose, eyes and frontal regions, which attacks had annoyed her for several years.

Her history states that she had not been well for 6 years, and she said that she had suffered from influenza and pneumonia about 2 years previously, and that she had had several attacks of pneumonia. She had been somewhat rheumatic during early life, had suffered from measles three times, had passed through scarlet fever and spinal meningitis, and had some catarrhal trouble. The paternal grandmother appeared to have died from tuberculosis. There was nothing else of interest in the heredity.

During the attacks of which she specially complained, the eyes, nose and the lips would swell greatly and this would be followed by coldness of the nose with blanching of the surface. The symptoms were usually severe for about 12 hours. The attacks were sometimes brought on by exposure to a slight mist, by blowing the nose or even by rubbing the eyes, by exposure to cold drafts, or dust or by reading by artificial light. They were aggravated in damp weather. During the paroxysms her voice would be lost and the breathing would become asthmatic. The nasal and facial symptoms were generally unilateral.

At the time I saw her, she had lost 25 pounds in flesh being reduced to 125 pounds. She was weak, pulse was 96 and the temperature was 99 2-5, but there were no cough or expectoration. The appetite was fair and the digestion good, but she had suffered from constipation for many years.

I found a good deal of thickening of the mucous membrane over the tuberculum septi and found the mucosa extremely sensitive over the whole of the inferior turbinated bodies of both sides, over the posterior 3-5 of the septum on the right side and over the posterior 4-5 of the septum on the left side. She told me that cocaine acted badly with her, therefore, the treatment by cauterization seemed impossible. In this emergency I gave her for use at home by atomizer, 3 to 5 times a day during the attacks, the extract of adrenal glands as follows:

Dessicated adrenal glands..... dram I  
Acid Boric .....grs. XVI  
Aqua Cinnamomi.....fluid drams IV  
Aqua, Camphor (hot).....fluid ounce I  
Aqua, Dest. (hot).....ad fluid ounces II.

These were to be macerated for 2 hours and then filtered. I saw her again last month and she reported that upon using this spray, she would be immediately relieved and that as a result of its repeated use, the symptoms

had almost entirely disappeared; but she believed the fresh solution acted somewhat better.

Case II. Miss L. C., age 21, dressmaker, was examined Nov. 17, 1902. History: Father and mother living and in good health. An uncle died of pulmonary tuberculosis. When 9 years old had a severe attack of pneumonia and since then considerable cough. Never had malaria. Has had no other illness. Takes cold very easily and is of a nervous temperament. Menses are very irregular, generally delayed. General health good, excepting sometimes now and then an attack of indigestion with eructation of gas. Bowels regular, weight 100 pounds, and increasing gradually. Complains of a swelling involving the right side of the face, particularly the cheek down to the neck standing out from  $\frac{1}{4}$  to  $\frac{3}{4}$  of an inch, also swelling of the upper lip and slight swelling of opposite cheek. Similar edema has occurred at intervals for four years, but the present case has been constant for 18 months though with frequent acute exacerbations occurring at intervals of from two to four weeks. The acute swelling is usually worse at night and it lasts several days especially when she is suffering with a cold. The exacerbations are usually associated with acute colds which generally cause obstruction of the right side of the nose, attended by sneezing and wheezing with very profuse discharge from that side. The discharge is thin and watery and contains no pus, but the left side is generally quite free from discharge.

The swelling sometimes closes the right eye and tear duct and is aggravated by wind. The swollen part is not painful to the touch. It is soft like the normal cheek, though she says it is tense when the attacks are severe; does not pit on pressure; is slightly red and has general appearance of a swelling due to an ulcerated tooth. The teeth are good. During some of the attacks the right hand becomes stiff and swollen and for several months a red spot about  $1\frac{1}{2} \times 2$  inches in diameter appeared at times over the right clavicle. She has dull headache often and some dizziness. Temperature 100.8, which is higher than any previous record in the course of her sickness—average about 98 to 99. Pulse 120. Some rheumatic pains in right arm for last few days.

Examination of chest negative. Examination of nose, left side, free, small exostosis on lower part of septum. Right side two-thirds closed by swelling of inferior turbinated body, middle turbinated not swollen. Decided hypersensitiveness of the mucous membrane on posterior half of right naris and some on the left. Tonsils somewhat enlarged, vault of pharynx normal on palpation, tongue clean, trachea not examined. From the fact that these attacks have often been ushered in by sneezing, it is probably that the source of irritation is located in the hyperaesthetic mucous membrane of the right naris. I have recommended treatment similar to that adopted in the foregoing case.

The predisposing causes of angioneurotic edema are found in heredity and conditions causing mental, nervous or physical exhaustion.

Nervous affections of various kinds in the family may justify the theory of heredity even though there may have been no manifestations of this particular disease; or various conditions may have caused the exhaustion that favored the attack; but in many cases as in the second of these there was no apparent predisposing cause. The first of these, however, had suffered from neurasthenia for years. Among the exciting causes are exposure to cold, malaria, tobacco, alcohol, traumatism, and strong emotions, etc. In some cases local sites of irritation are discovered as was well marked in the first of these, and I hope the local seat of irritation may be the same in the second.

The face, lips, tongue, genitals and extremities are most often affected, but other parts may be involved in the sharply circumscribed or more diffuse swellings. It is often attended by many of the well known symptoms of urticaria.

Disturbance of the stomach and colicky pains with vomiting or diarrhoea are very common symptoms. Difficult deglutition and dyspnoea are present in some cases and the latter has proven fatal. In one of these cases the asthma was probably due to edema. Unless the cause and the local seat of irritation can be discovered, the prognosis is not favorable and usually treatment is very unsatisfactory.

#### Discussion on Dr. Ingall's Paper.

John E. Rhodes: I have recently had a well marked case of hyperaesthetic rhinitis, although the patient did not have the angioneurotic symptoms spoken of by Dr. Ingalls. The case was so aggravated that cauterization of the sensitive area was followed by such marked reaction at one time that the inflammatory condition extended to the middle ear, and I was obliged to discontinue that treatment. I then used adrenalin chloride, 1-5000. The symptoms have been somewhat relieved, but the case has not been observed for a sufficient length of time to know what the ultimate result will be.

#### EXHIBITION OF WOODS' METAL CASTS OF THE EAR.

By George E. Shambaugh.

A cavity can often be best studied by means of a cast. This is particularly true of the cavities that go to make up the middle and the internal ear. These cavities are very intricate in their arrangement, they are crowded together in a very small space, and are surrounded by the bony shell of the temporal bone. These facts render their study by the ordinary methods of sections, etc., very unsatisfactory. Anatomists have long made use of casts in studying the internal ear. The first cast of this kind is said to have been made as early as 1827. Hyrtle in 1845 published a systematic study of the comparative anatomy of the internal ear, in which he used the method of making casts of the labyrinth. Bezold, in 1882, was the first to apply this method in



the study of practical otology. He made wax casts of the middle and internal as well as of the external ear.

Siebenmann has made some very perfect casts of the middle ear, and has also made an exhaustive study of the aqueducts, etc., of the internal ear by means of Woods' metal casts. The casts I have here are of the middle and internal ear. Such casts are of the greatest service in teaching the anatomy of the ear. The method used in making Woods' metal casts must be modified somewhat to suit the cavity. When making a cast of a cavity like the antrum of Highmore or the frontal sinus, a perfect cast can be obtained by simply pouring the molten metal directly into the cold cavity. When making casts of intricate cavities like those of the ear, it is necessary to thoroughly heat the bone before pouring in the metal, else the metal will cool and harden before it has filled all the minute spaces. To get rid of the bone, a strong solution of K O H can be used.

John Edwin Rhodes, Official Reporter.

The Chicago Medical Society held a regular meeting January 7, 1903, with President Wm. A. Evans in the chair.

G. Frank Lydston read a paper entitled **Notes on Plague as Observed in Sydney, New South Wales.**

The author stated that the city of Sydney has had two epidemics of plague, the first in 1900, and the second in 1902. The latter epidemic was over before his recent visit to Australia. The Sydney epidemics gave the only opportunity the world has thus far experienced for the study of plague among civilized white people under modern scientific conditions by men fitted by experience and laboratory technique to make observations of true value. The author obtained much of his information regarding the plague from Ashburton Thompson, president of the Sydney Health Board.

The first epidemic comprised 303 cases, 293 whites and 10 Chinese. The mortality was a little less than 34 per cent, but the mortality rate among the Chinese was 80 per cent. This race seems comparatively non-resistant to the disease. The 1902 epidemic comprised 141 cases. The proportion of Chinese and the mortality rate were not widely different from the 1900 epidemic. The origin of the plague was probably Hong Kong via Noumea, New Caledonia. The method of transmission was mentioned.

The study of plague in Sydney has established the fact that the bubonic and septicemic forms, at least, are not catching. That this is not true of "primary plague pneumonia" is probable, and great caution is to be observed here. The bubonic type was the prevalent one in Sydney, a few cases only of the septicemic form being noted. The patients were treated at the hospital with Yersin-Roux anti-plague serum, and the contacts were inoculated with the Haffkine prophylactic serum if they so desired.

In regard to these serums, the conclusions drawn by the health board are:

1. That the value of the prophylactic serum is doubtful.

2. That the use of the prophylactic serum is attended with obstacles which make it almost impracticable, irrespective of its intrinsic merits.

3. That the Yersin-Roux serum is also of doubtful value as a specific. Its action as a temporary reviver or cardiac stimulant seems to be demonstrated.

In the first epidemic there were 11,000 preventive inoculations. There was only one fatal case of plague in a vaccinated case. Even this was doubtful, but this experience could hardly be said to prove anything.

The prevention of plague seems to be reduced to very simple principles. These are:

1. Prevent rats from getting ashore from vessels by mooring some little distance from the wharf and freshly tarring all ropes, fenders and hawsers which extend from the ship to the wharf. All gangways should be drawn up when not in use. When used at night, gangways and the wharfs should be brilliantly lighted.

2. All ships should be thoroughly fumigated with sulphur or formalin before entry and departure. This is very effective in destroying rats.

3. Great pains should be taken to keep advised of the health of rats in exposed cities. Any unusual movements or mortality among them should be at once reported to the health authorities. Laboratory study should be constant.

4. The number of rats should be kept down, so far as may be, at all times, and especially when cases of plague are found. Fully fifty thousand rats were destroyed in Sydney within a few weeks, yet the number of rats was seemingly the same. There are, of course, many sources of error here, and, admitting the apparent fact, a simple explanation would not be far to seek. The equilibrium between the number of rats and the means of subsistence is pretty constantly maintained. A reward was offered for rats in Sydney, sixpence each being finally given. This bounty was too high. Rats breed fast, and mature quickly, and it would pay to breed them at that price. Probably this was not done.

5. No matter how remote the chances of contagion, so infectious a disease as plague demands isolation and great care to avoid immediate infection.

6. A general cleaning-up is required in districts characterized by bad sanitation. This is especially necessary because the destruction of scavenger rats demands in all fairness an equally efficient substitute for scavenger work.

7. Fumigation of all infected and suspected premises. If properly done, rats are destroyed at the same time.

It is interesting to note that in 23 cases of plague in Western Australia in 1900, 21 were white and 2 Chinese. Both Chinese, and only one white, died.

Jacob Frank asked Dr. Lydston whether fire was used during the epidemics in Sydney



to check the bubonic plague, as this was done in Honolulu, the infected districts being destroyed by fire.

A. W. Baer said that rats do not like fire very well, and anyone who has watched fires in old buildings in which there are many rats must have noticed that they made every effort to escape. He has seen a great many rats killed in that way but others have escaped.

Dr. Lydston said that he had inquired into the matter of burning buildings in Honolulu with a view to preventing the spread of bubonic plague, and exterminating rats by fire. He said that this was considered a very illogical way of dealing with the plague.

Alice Hamilton followed with a paper, illustrated by numerous charts, entitled **The Part Played by the Common House Fly in the Recent Epidemic of Typhoid Fever in Chicago.**

Abundant evidence was advanced to show that flies are common carriers of this disease.

Wm. Fuller read a paper entitled **Polymazia.**

The author stated that elevation without nipples in the neighborhood of the thorax or axilla should give rise to the suspicion of a mammary gland. After going extensively into the literature of polymazia, he reported the case of a married woman, aged 22, pregnant the first time. In May, 1902, she consulted him in reference to small swellings which had made their appearance several months previously in her arm-pits. The discovery was accidental. They enlarged in size, and became more tender. The patient was instructed to return in a month for a second examination at which time the real nature of the axillary swellings still remained undetermined. No change was found except a slight increase in the size of the tumor. In the latter weeks of pregnancy, which was terminated November 10, 1902, the left axillary swelling became very full and distended, and resembled in every way the normal breast on that side. During the advent of lactation this condition was greatly intensified, and was more marked than in the normal mammary glands. Pain at this time greatly exceeded that in other mammary glands, and gave great discomfort to the patient. When the child would suckle at the right breast, the accessory gland upon that side (right axillary) would become soft and flaccid, but a like condition was not seen in the left axillary enlargement when the left breast was emptied. The patient's clothing upon the left side was kept constantly wet, due to a constant oozing from small openings at the summit of the axillary gland. By taking hold of the axillary gland and making moderate pressure, the surface having been well dried, small drops of fluid would quickly accumulate on the surface. This experiment was repeated until satisfaction was complete regarding the source and quality of the fluid. At the end of three weeks the condition, as it existed at that time, was photographed. Two views were taken; each showed fairly well the supernumerary gland in the left side. In order to verify a diagnosis already quite positive, the essayist resorted to Goldberger's test, removing the hair from the left axillary space

and thoroughly cleaning the skin, after which a hypodermic needle was passed directly into the gland tissue, and several drops of a white fluid were withdrawn and placed in a small bottle. A breast pump was used to withdraw milk from the normal mammary gland, which was placed into a second bottle, and the two submitted to a Laboratory for examination. It was reported that the fluids were identical. This confirmed the diagnosis. A peculiar point in the author's case is the areola without a sign of a nipple. In the many cases in literature he fails to find but one similar case reported by McGillicuddy.

Are such cases congenital? If not, how do they occur? It seems rational to coincide with some authors, who explain the phenomena thus: In the process of development, parts of the normal gland have been split off and have separately developed. The cases collected by the author from the literature have occurred above or below the normal mammae, and near or in the axillae. It seems natural that mammary glands should appear on the anterior part of the body, be they as high up as the axilla or as low down as the pubes, as such are commonly found in the lower vertebrates, and may occur in the human being.

S. Eisenstadt said it was claimed by some that the position during sleep bears an etiological relation to the development of supernumerary glands, and questioned the essayist in regard to that point.

David H. Monash asked whether any of the glands had become affected with carcinoma or other tumors.

Dr. Fuller, replying to the question of Dr. Eisenstadt, said he had never known or heard of the position during sleep bearing an etiological relation to the development of supernumerary glands.

As to the remarks of Dr. Monash, he could not recall that any of the glands were affected with either carcinoma or other tumors.

#### Chicago Medical Society.

A regular meeting was held Jan. 14, 1903, President, Wm. A. Evans, in the chair.

#### Treatment of Progressive Deafness Based on Differential Diagnosis.

The author of this paper, J. Holinger, stated that in treating cases of progressive deafness otologists obtained excellent results in some cases, while in others, apparently identical so far as the conditions were concerned, the results are disappointing, both to the otologist and patient. Formerly, the result of the treatment, rather than the examination, revealed the diagnosis. "Treat the patient for two weeks, and you will see whether or not he can be cured" is the advice given by textbooks. He said the consequence of this empirical and unscientific method was mistrust of the profession against the men who represented this specialty, the prejudice of the public amounting to complete Nihilism, which was expressed in these words, "Nothing can be done for the ears," and consequently the patient was tossed like a ball from one doctor to another without getting a definite answer to the question, "Will

I hear again?" He believes that either yes or no is the answer that can be given in over ninety-five per cent. of the cases after the first examination.

Before reporting cases, he gave a short sketch of the development of our knowledge in this direction. The knowledge that several pathological conditions can produce the clinical picture of progressive deafness is old, and a number of names were supplied, such as dry catarrh, hypertrophic catarrh of the ear, catarrhal deafness, etc., which had little meaning for the pathologist. Ankylosis of the stirrup in the oval window was a pathological condition known to be a cause of deafness. However, no knowledge of the symptoms existed, and hence no diagnosis *in vivo* was possible until Bezold, in 1885, first showed that in a patient, who, during his life, suffered from progressive deafness with only one pronounced symptom, namely, a constantly negative Rinne test; there were extensive changes of the bone surrounding the labyrinth which led to ankylosis of the stirrup. During the following ten to fifteen years large numbers of examinations were made by Bezold, Politzer and Siebermann, which led, on the one hand, to the establishment of a characteristic group of symptoms, together with what is known as Bezold's tripod of symptoms, and, on the other hand, to the recognition of a pathological process in the temporal bone described as spongifying, which takes place in the bony capsule of the labyrinth, most often in the neighborhood of the oval window, and which in some cases leads to ankylosis of the stirrup in the oval window. The symptomatology and pathology becoming more and more known, a scientific basis was created, and a large number of cases of deafness were defined and differentiated from the rest. These were the cases that from the start proved intractable to any treatment, and many of the cases after years of treatment were worse than those that were of equally long standing, but had never been treated.

The influence of long treatment is shown in the following case: Mr. E. A. V., forty-five years old, dentist in Salt Lake City, was referred to the author by Professor Senn, Dec. 11, 1900. He could not hear loud shouting in either ear. In 1894 he noticed, first, that he became deaf, but his wife states that the trouble dated farther back. For five or six years he was faithfully treated in Salt Lake City, with massage, inflation of the Eustachian tubes, cauterization, and trephining of the nose, etc., etc. His ears never discharged or pained him. Both drumheads were normal, and the air entered freely through the Eustachian tubes into both middle ears. The only remnant of hearing which was left was a small insula from e to a by air conduction, and a for a short time by bone conduction. Patient is certain that the treatment impaired his hearing. The author's directions, therefore, in all similar cases have been to keep away from treatment. A similar case was reported.

The other group of cases mentioned by the author are those of affection of the Eustachian tube, which often gives excellent results and

always has a more favorable prognosis. The Bezold tripod is absent. Here the diagnosis often calls for persistence in treatment, and demands patience where success is slow. Cases falling under this head were reported.

In closing, the author desired to leave the impression that otologists need not depend upon haphazard methods, but he believes they can make a final diagnosis and prognosis after the first or second examination in these cases of progressive deafness. The advice of textbooks for trial treatment of two weeks is frequently not enough, but often it does harm.

Joseph C. Beck stated that the subject of spongifying of the labyrinth is comparatively new, and it is not an easy matter to make a diagnosis in such cases. Abroad, in Siebermann's clinic, a great deal of this work has been done. Siebermann, he says, is quite an enthusiast in this line of work, as is also Bezold. Knapp, of New York, has published an article in which he gives a translation of some of Siebermann's work, and has given a beautiful illustration of this pathological condition. Regarding the tripod of Bezold, he did not think it was so absolute in this particular condition.

W. L. Ballenger said this subject had engaged his attention for the last two or three years, and thus far he has been unable to diagnose so-called spongifying of the labyrinth. The tripod of Bezold, he said, is not to be depended on. Spongifying of the labyrinth may affect the contents of the middle ear or ossicles. It may affect the region about the oval window or the deeper parts around the labyrinth itself. If the spongifying process happens to be located so as to involve the labyrinthine portion of the ear, then we would get signs of labyrinthine disease. If the spongifying process happens to affect the ossicles of the middle ear, then we have the ordinary signs of middle ear disease, so that the stereotyped Bezold tripod could not be depended on.

N. H. Pierce said the work of Siebermann and Bezold in this direction characterizes the greatest advance that has taken place in otology in the last fifteen years. Dependence upon the so-called tripod was not urged by any of these authors who have had to do with this spongifying process. Siebermann called the attention of the profession to the fact that all cases of deafness are not due to a catarrhal process. He discovered that certain changes took place in the temporal bone about the footplate of the stapes and along the osseous wall of the labyrinth, which were entirely separate from any catarrhal changes in the middle ear. These changes were characterized by what has been termed a spongifying process in this portion of the labyrinth.

#### A Case of Spina Bifida Without a Sac.

A. R. Small read a paper on this subject and reported a case. At 8 P. M., Dec. 29, 1901, he was called to attend Mrs. G. L., aged 20, a primipara, in the first stage of labor. The cervix was just beginning to dilate; and the first stage of labor was not completed until afternoon of Dec. 30th. The position was L. O. A., the pelvis normal, but the pains were



weak and inefficient. Towards midnight, as the natural pains seemed entirely inefficient to accomplish delivery, he applied the forceps. There was no rupture of the perineum, but a slight tear simply through the mucous membrane at the entrance to the vagina on the left side, which was immediately repaired and healed by primary union. The mother recovered without a particle of fever.

On examining the child, he found the following conditions: At the point at which spina bifida is usually found, i.e., at the junction of the lumbar vertebra and sacrum, there was entire absence of membrane of any kind over the cauda equina, for the space of one inch. The skin was wanting over a space two and a half inches in diameter, and from the edge of the skin there was a gradual slope to the cauda equina, which could plainly be seen for the space of one inch. As there was no membrane whatever present to cover the cord, he decided to trust to nature to throw up granulations over the cord as the best measure of repair, fearing, however, that before nature could repair the defect the spinal canal would become infected, or the drainage of the spinal fluid would prove fatal. He placed quite a large pad of absorbent cotton over the parts, secured by a bandage. The drain of spinal fluid was quite large. He had no way of estimating the exact amount, but the dressings were saturated several times a day. He thinks there must have been several ounces of fluid lost daily. Granulations filled in rapidly, and the cord, or cauda equina, was entirely covered by granulations at the end of a week, and the spinal fluid had ceased to flow. There were no convulsions, nor other nervous symptoms. During the first week, while the spinal fluid was flowing out so copiously, the babe passed very little urine, but as soon as the flow of spinal fluid was shut off by granulations, the flow of urine became free. Healing continued, and at the end of a month the opening was entirely filled up with granulations and covered with skin.

He called May 12th, 1902, to see the child, and found that hydrocephalus had developed. The mother told him that the child had not been ill at any time except having had a slight cold. Hydrocephalus in this case was probably due to shutting off the flow of spinal fluid after it had been formed so abundantly. It seemed remarkable to him that the child could lose so much spinal fluid for several days, one week, without any symptoms of disturbance. Probably it had become accustomed to such loss in utero. When the membranes ruptured during labor, the contents of the amniotic sac had a milky appearance, probably due to the admixture of spinal fluid.

The author had searched the literature at his command, but failed to find a parallel case. Cases of spina bifida are comparatively not infrequent, but cases of entire absence of any kind of membrane over the cord, he believes, are rare.

J. Pennington exhibited a glass tube for X-Ray purposes which he had been using in treat-

ing diseases of the rectum, with considerable satisfaction.

A committee, consisting of J. A. Capps, M. L. Harris and F. Robert Zeit, appointed for the purpose of drafting resolutions in regard to the death of **Major Walter Reed**, made the following report, which was adopted:

In the death of Major Walter Reed, U. S. A., the medical profession has lost one of its most distinguished members. Dr. Reed was graduated from the medical department of the University of Virginia in 1869, and from the Bellevue Hospital in 1872. In 1875 he became assistant surgeon in the United States Army.

A determining period of his life began when he undertook the special study of bacteriology and pathology under the stimulating influence of Dr. Welch at John Hopkins University. His contributions on experimental subjects and later his conduct of the Army Medical Museum bore the stamp of exceptional ability. When he undertook the investigation of yellow fever and its cause every step of the procedure marked the workings of a trained mind combined with a tireless energy and undaunted courage. Without hesitation he carried through a series of experiments which endangered his own life and that of other volunteers to prove that a mosquito is responsible for conveying contagion of yellow fever. As a result of his suggestions preventive measures were instituted in Cuba which have already robbed the scourge of its terrors.

Resolved, That the Chicago Medical Society record an expression of its regret in the untimely death of Dr. Reed, and be it

Resolved, That the above be entered in the minutes of the Society and a copy of the same be forwarded to his widow.

#### Report of the Civil Service Committee.

The following resolutions were submitted by the committee:

Whereas, The Committee appointed by the Chicago Medical Society to co-operate with the Illinois Civil Service Association has carefully examined and strongly approved the Civil Service bill drafted by the Association, and,

Whereas, Said Committee is familiar with the need of such a law as that embodied in said bill, especially as it relates to charitable institutions; therefore, be it

Resolved, That the Chicago Medical Society strongly endorses said bill, and agrees to further the efforts of the Illinois Civil Service Association in every way possible; and, further, be it

Resolved, That the President of the Chicago Medical Society name five members to serve on the campaign committee, such members to represent, as far as possible, different senatorial districts.

William Cuthbertson, Chairman.

James H. Stowell,

Isaac A. Abt,

David J. Doherty,

Julia Ross Low.

On motion the report of the Civil Service Committee, with the resolutions, was adopted.



The Chicago Medical Society, held a regular meeting Jan. 21, 1903, with President, Wm. A. Evans, in the chair.

F. Kreissl read a paper entitled **A Contribution to the Diagnosis and Treatment of the Surgical Diseases of the Ureter and Kidney.**

The first case reported by the author was one of hematuria, in which he resorted to nephrotomy. The patient was 45 years of age. In March, 1902, the patient had hematuria, accompanied with tenesmus at times. Rest in bed for several days reduced the quantity of blood materially, so that the urine sometimes seemed to be almost clear. The hematuria, however, returned soon after the patient was up and about a few hours. Examination revealed the left kidney larger and more resistant than the right one. There was no family history of consumption, malignant growth, or of syphilis or a trauma. From the right ureter clear urine was secreted, while bloody urine escaped from the left side. No. 8 ureteral catheter, French scale, was passed without difficulty into the renal pelvis, and bloody urine collected for examination. The same procedure on the right kidney furnished clear urine. Excluding a gumma of the kidney and essential hematuria, there remained as a more common cause tuberculosis, stone, malignant growth, or nephritis. The result of the examination of both urines was given. In the skiagraph taken the following day a shadow was noticed, the density and position of which might lead one to make a diagnosis of a calculus of the ureter caught at its third narrowing in the bladder wall, but closer study made it evident that the shadow was not a ureteral calculus. The distance of each ureter from the median line was less than one inch. If, in this case, the distinct shadow was a ureteral stone, the author thinks it ought to be about midway between the median line and where it appears on the skiagraph. A second exposure, made four days later, showed the same condition. Inasmuch as he had no difficulty in passing a ureteral catheter up the ureter and obtained bloody urine direct from the renal pelvis, he thought he was justified in eliminating the existence of a stone in the vesical portion of the ureter, or its possible bearing on the hematuria. To ascertain the cause of the hematuria, he made a lumbar incision Oct. 15th, and found a very large, congested, cyanotic kidney, but microscopically nothing pathological on its surface, nor on the cut surface of the parenchyma, in the calices, or the renal pelvis. A good-sized elastic bougie was easily passed down the ureter into the bladder, without encountering an obstruction. The urine was closely inspected for three weeks following the operation, but no concrement found, neither could a stone be seen on subsequent cystoscopic inspection of the bladder cavity. Patient has gained in weight since he left the hospital. The urine cleared up during the second week after the nephrotomy, and has remained free from albumin and blood.

In analyzing the reports on essential hematuria, especially those in which an anatomical examination followed the clinical observations, there were scarcely any found in which the

upper urinary tract was normal. In most of them hepatic lesions existed, sometimes so small that they were not considered as the cause of the hematuria. It is also of interest to know that in many cases of nephritis, complicated with hematuria, examination of the urine gave a negative result, while a subsequent anatomical investigation of the extirpated kidney proved the presence of this pathological condition.

#### Ureteral Calculus.

The second case was interesting on account of the unusual size of the ureteral calculus. The ureteral obstruction was caused by a calculus, whose diameters were  $1\frac{1}{8}$  by  $\frac{7}{8}$  inches. This case showed to what extent the ureter may be distended by a calculus, and yet urine escaped alongside the partial obstruction, as the author could see through the cystoscope distinct jets of urine emitted at frequent intervals. The peculiar location of the stone in this case renders operation rather difficult. The author states that the perineal route for such cases is not considered a favorable one, and the extraperitoneal route does not give much space to work deep in the pelvis. The transperitoneal method is not without danger, on account of a possible infection. When the patient makes up his mind to undergo an operation, the author proposes, after removing the stone, to pass a ureteral catheter *a demeure* through the bladder into the renal pelvis, then close, as far as the thin and disintegrated walls will permit, the ureter by Lambert sutures, unite the parietal peritoneum over it, leave a drain in the cavity for quite a while, draining all the urine from this side until the wound in the peritoneum is firmly closed.

The third case was one of renal tuberculosis in a man, forty years of age, who gave a history of repeated attacks of gonorrhea within the past fifteen years. A bacteriologic examination of the urine and cultures corroborated the diagnosis. It was impossible to trace positively the source of the infection with tubercle bacilli. Considering the suspicious condition of the right kidney, the author thinks nephrectomy in this case is out of the question.

Regarding the treatment employed, after emptying the renal pelvis and irrigating with an oxycyanide of mercury solution through the ureteral catheter, he injected gomenol, and while withdrawing the catheter he deposited some of it in the ureter and bladder. Besides these applications, he injected the oil hypodermatically, after noticing a marked decrease in the number of tubercle bacilli within two weeks. Under this treatment the patient's condition has improved considerably. While the author thinks it would be premature to draw definite conclusions from the few cases in which he has employed gomenol, and without considering it to be a specific for tuberculosis of the urinary tract, he nevertheless believes that it is a remedy capable of effecting good results in bacterial infections of this tract.

A. E. Halstead referred to the possibility of there being such a thing as an essential hematuria. He saw a case that had been operated

upon for essential hematuria. After the kidney was opened, nothing was found which was considered to be the cause of the essential hematuria. He operated on the same patient subsequently, and found a small tumor in the pelvis of the kidney, which he thinks was the source of the hemorrhage. It was a papillomatous growth that bled profusely on the slightest trauma.

As to the case of ureteral calculus reported by Dr. Kreissl, he thought the most interesting point was that the patient was able to pass urine with such an apparent ureteral obstruction.

William Cuthbertson stated that the essayist pointed out very clearly the necessity of not relying on any one method of diagnosing the presence of an ureteral calculus. Dr. Kreissl's case clearly demonstrates the efficacy of the combined method of X-Ray skiagraphs and the use of the ureteral catheter.

Dr. Kreissl, in closing the discussion, stated that he tried to show that there was no such thing as essential hematuria; that it is a symptom of some disease which exists in the upper urinary tract, which may not have advanced so far as to be visible after opening the kidney.

Wm. Cuthbertson read a paper entitled **A Contribution to the Surgery of the Ureter**, with report of a case.

The author stated that ureteral injuries occurred in spite of the most painstaking care on the part of the operator, and its possibility is one of the gravest objections to operating by the vaginal route. In abdominal operations, however, the surgeon can, in the large majority of instances, see what structures he is handling, and even if the ureter is displaced by a new growth, inflammatory products, or is abnormal in its course, it can be recognized and avoided. In vaginal operations the position of the ureters must be taken for granted, unless they have been previously catheterized, and the catheter left *in situ*, and the operator proceeds, trusting that they may not be injured.

After referring to the work of Maydl, Peterson, Martin and others, which has proven that uretero-rectal anastomosis is not an operation followed by permanent recovery, owing to an ascending infection, etc., the author described at length uretero-cystostomy, an operation which he performed on the following case:

The patient, a woman, 26 years of age, was admitted to his service at St. Luke's Hospital, July 1, 1902, with a discharge of urine from the vagina. She had had a vaginal hysterectomy and double salpingectomy performed on May 9th previously. As there was a question as to whether she had a vesico-vaginal or a uretero-vaginal fistula, he injected a solution of methylene blue into the bladder and closely watched the fistula to see if any of the solution passed through. As the urine in the vagina remained perfectly clear, vesico-vaginal fistula was excluded. Dr. Kreissl then passed a ureteral catheter. He found it impossible to pass a catheter into the left ureter beyond three-quarters of an inch, while, on the right side, a catheter could be inserted up to the kidney.

From these results a diagnosis was made of injury to the left ureter. On July 17th he operated on the patient, assisted by Drs. Kreissl and Watkins, for the purpose of implanting the ureter into the bladder, this procedure being planned on account of the impossibility of passing a catheter beyond the ureteral opening, which indicated that the ureteral injury was near the bladder.

The abdomen was opened in the median line; the intestines were well packed off with gauze pads, and the posterior parietal peritoneum opened over the usual course of the ureter. Great difficulty was experienced in recognizing the tube, on account of its enormously dilated condition, and the consequent thinning of its walls. It was thought at first to be the iliac vein, until it was followed up above the brim of the pelvis and found to lead directly to the kidney. After its positive recognition, it was followed down and found to enter at the vault of the vagina, into which it opened, surrounded by a mass of dense scar tissue. The adhesions were finally separated, the end of the ureter brought up, amputated obliquely, and inserted into the opening made in the bladder wall at its highest point, a row of catgut stitches to hold it in place completing that part of the operation. A retention catheter was placed in the bladder and the patient put to bed, in a good deal of shock, from which she rallied nicely in the course of twenty-four hours.

From July 17th to Sept. 2d, the temperature remained practically normal, and urine was passed freely through the catheter and urethra. On Sept. 2d the patient complained of feeling chilly, and the temperature suddenly jumped to 104.6°; pulse 128; respirations 22. This high temperature continued for two days, and then became normal. The amount of urine passed by the urethra began to diminish, and on Sept. 7th urine made its escape through the abdominal wound. On account of the depressed condition of the patient, further operation was postponed until she could regain her strength.

On Oct. 4th the second operation was performed by himself. After freeing the ureter and again amputating the end, it was found to be considerably shortened. At this operation Cushing's suggestion was adopted, and after making a new opening into the bladder a ureteral catheter was passed up into the proximal part of the ureter, two long silk sutures were inserted, one through each side of the tube, the catheter and sutures grasped in the bite of a forceps passed through the opening made in the bladder wall at its highest point, and the whole drawn out through the urethra. These silk sutures were caught by a fresh pair of forceps, put on the stretch, and carried up on to the abdomen, where they were fastened by a broad strip of adhesive plaster. The ureter was again stitched to the bladder by catgut sutures, the abdomen closed, and a cigarette drain passed down to the anastomosis.

The patient was put to bed in good condition, and from this operation made an uninterrupted recovery. The ureteral catheter was



left in place for seven days, after which it was withdrawn. During its retention it became encrusted with urinary concretions, which were expelled after its removal. The sutures were withdrawn at the end of five days.

The results of this operation proved (1) the efficiency of silk sutures in holding a shortened ureter in the bladder opening, thus doing away with severing the anterior bladder attachments in certain selected cases. (2) Safety and advisability of leaving a ureteral catheter *in situ* in the operation of ureteral cystostomy.

Sixty-eight new members have been admitted. Addresses are always in Chicago unless otherwise stated.

Aiken, A. W., 100 State st.  
 Almes, Hermann E., 4249 Indiana ave.  
 Anker, I. C., 5008 S. Calumet ave.  
 Bell, Archibald, 5850 S. Halsted st.  
 Block, M. E., 1997 Lincoln ave.  
 Brennermann, Joseph, 553 W. 63d st.  
 Brown, A. C., 4259 Cottage Grove ave.  
 Burr, Franklin K., 6100 Normal ave.  
 Carlstein, John A., 1240 E. Ravenswood Park.  
 Cunningham, J. K., 5101 S. Halsted st.  
 Darling, C. G., 3823 Lake ave.  
 Davis, W. C., 369 E. 63d st.  
 Dinsmore, Walter H., Kramer, Ind.  
 Dodds, George D. B., 1554 Jackson Blvd.  
 Dolpp, William L., 34 Washington st.  
 Doyle, L. M., 9250 Cottage Grove ave.  
 Eggert, F. C., 5258 S. Halsted st.  
 Galliver, G. A., 1256 Perry ave.  
 Galliver, Lillian E. C., 1256 Perry ave.  
 Garvey, A. Cosmas, 1306 Wilson ave.  
 Gilmore, N. S., 7210 Woodlawn ave.  
 Grosskopf, Ernest C., Milwaukee County Hospital, Wauwatosa, Wis.  
 Hagey, H. H., care C. Lovewell, 6028 Wentworth ave.  
 Hamilton, R. J. C., 176 Sedgwick st.  
 Hancock, Joseph, 3754 Indiana ave.  
 Hartmann, W. W., 416 Winthrope ave.  
 Hartung, C. J., 499 29th st.  
 Heath, Clarence W., 100 State st.  
 Hill, Charles, 6330 Kimbark ave.  
 Herschfield, S. H., Winnetka.  
 Horton, Estella, 400 W. 65th st.  
 Hook, Merritt B., 1525 N. Rockwell st.  
 Houston, J. P., 1180 Sheffield ave.  
 Hunt, Frederick R., 409 N. Pine ave.  
 Hunter, Mary P., 28 33d Place.  
 Hyde, Edward E., 103 Dearborn ave.  
 Jefferson, T. A., 1745 N. Clark st.  
 Kearney, Joseph M., Dunning.  
 Kerber, H. C., 4338 Indiana ave.  
 Korssell, C. F., 5500 Wentworth ave.  
 Lewke, O. W., 996 N. Oakley ave.  
 Mersheimer, J. W., 1751 Milwaukee ave.  
 Miller, H. W., 28 33d Place.  
 Miller, Maude A., 28 33d Place.  
 Miller, A. Merrill, 214 Daniel Bldg., Danville.  
 Mitchell, O. L., 3500 S. Halsted st.  
 McDonald, James H., 13248 Ontario ave.  
 McOnarrie, J. K., 1657 W. 69th st.  
 Nowlin, John H., 1653 W. 63d st.  
 Phifer, C. H., 4147 Lake ave.  
 Phillips, N. A., 50 W. Madison st.  
 Pratt, Irene R., 1311-103 State st.  
 Reinhardt, Henry G., 1312 N. Western ave.

Reiterman, C., 5614 S. Blvd.  
 Ruehl, M. C., 188 N. Clark st.  
 Searle, C. H., 67 75 Wells st.  
 Shumway, E. B., 2302 Archer ave.  
 Small, Arthur A., 575 E. Division st.  
 Tallman, E. D., 338 W. 87th st.  
 Taylor, S. L., 165 Chicago st., Elgin, Ill.  
 Vernier, Jean A., 3558 S. Halsted st.  
 Wald, O. E., 163 Lincoln ave.  
 Walker, Marie W., 70 State st.  
 Watts, G. W., 351 W. 63d st.  
 Weatherford, Franklin A., 1701 W. 63d st.  
 Wells, J. L., 3214 Malden st.  
 Wenstrand, D. E., Rush Medical College.  
 Zeltner, S. L., 2404 Milwaukee ave.

**The North Shore Branch of the Chicago Medical Society** was organized on Thursday evening, Jan. 15, 1903, with a charter membership of about thirty members. The meeting was held in the parlors of the Evanston Y. M. C. A. Building.

H. B. Hemingway was made temporary chairman, and M. S. McEwen temporary secretary.

W. A. Evans, president of the Chicago Medical Society, addressed the meeting, explaining the purpose of the proposed organization and its relationship to the Chicago Medical Society and to the State and American Medical Associations.

Wm. L. Ballinger was elected president and M. G. McEwen secretary for the ensuing year.

Great interest was manifested in the new organization and its future success and usefulness is already assured. There are about seventy physicians in the district, and it is the intention to enlist the interest and cooperation of all reputable physicians among them in the Branch and Chicago Medical Society. Membership in the branch society is limited to those who are members of the parent county society.

The North Shore Branch Society is but one of twelve similar organizations recently organized in various portions of the county.

**The North Shore Medical Society** held its regular monthly meeting Tuesday, January 6, 1903, at 8:30 P. M., in Bennett Hall, corner Wilson avenue and East Ravenswood Park.

J. H. Hoelscher read a very able and interesting paper on the subject of "Original Research in the Study of Human Sweat and Practical Deductions Therefrom." The paper was discussed by Drs. Abbott, Herzog and Green. Discussion closed by Dr. Hoelscher.

Dr. Herzog presented two gross and two microscopical specimens. It was moved and seconded that the society have a lunch served at the close of each of the meetings.

The secretary was instructed to send out notice just prior to each regular meeting.

The chairman suggested the subject of "Influenza" for the next meeting and called for volunteer papers.

The society adjourned to enjoy the hospitality of our chairman at lunch.

George Edwin Baxter, Official Reporter.

**The Southern District of the Chicago Medical Society** held a meeting December 11, 1902.



A constitution and by-laws were adopted. The constitution comprises the following points: The name shall be the Southern District of the Medical Society of Cook County. The members of this society are all members of the Medical Society of Cook County living in the Southern District as prescribed by the following boundaries, viz.: The river on the north, the center of 67th street on the south, the center of State street on the west, the lake shore on the east.

There are no dues. The by-laws name the third Thursday of each month from October to June, inclusive, as the time of meeting, while the third Thursday in May is to be the date for the annual meeting.

After the adoption of the constitution and by-laws officers were elected to serve until the annual meeting in May. They were: President, Wm. Cuthbertson; vice president, John L. Porter; secretary, W. S. Harpole; treasurer, C. P. Pinckard; executive committee, Geo. B. Dyche, D'Orsay Hecht, H. F. Lewis, H. W. Cheney and E. B. Tuteur; auditing committee, Paul Chester, J. C. Hollister and E. B. Hutchinson; program committee, D. F. Monash and F. X. Walls.

In addition to the committeemen elected the president and secretary are ex-officio members of the executive committee, and the secretary is a member of the program committee.

It was decided to hold the first regular meeting in January—on the third Thursday. At the meeting the secretary was instructed to make formal application to the Medical Society of Cook County for recognition as a local branch.

The Chicago Pediatric Society met in regular session Tuesday, December 16, 1902, in Schiller Hall, with the following members present: President M. P. Hatfield, J. C. Cook, A. C. Cotton, I. A. Abt, J. D. Merrill and E. M. Moore.

The following program was given:

"The Study of a Case of Summer Diarrhoea with Rare Complications and Sequelae," by J. V. Balderston.

"A Case of Hematemesis Accompanied by Bradycardia," by Dudley Jackson.

A. C. Cotton gave a report of the autopsy on the case of **Bulbar Paralysis** which he presented before the society in February, 1902.

J. V. Balderston and Dudley Jackson were elected to membership in the society.

On motion the meeting adjourned.

E. M. Moore, Official Reporter.

The Aux Plaines Medical Society met Friday, December 19, at the Park Hotel, Oak Park. The secretary reported the present membership to be 39.

The following applicants were duly elected to membership: Gustavus P. Head, Austin; Stella M. Gardner, Austin; Mary Jeanette Kearsley, Austin; Harry C. Worthington, Oak Park; Rosalie M. Ladova, Austin; Addison H. Foster, Oak Park; W. H. Peck, Oak Park; Charles E. Humison, Austin; Irene Robinson Pratt, Austin; Frederick R. Hunt, Austin;

C. Reiterman, Austin, and Thomas E. Roberts, Oak Park.

The following officers were elected for the coming year: W. T. Pickard, president, Maywood; Arthur Loewy, vice president, Oak Park; board of censors, C. E. Hemingway, Oak Park; Charles W. Olcson, Lombard, and H. W. Merrell, Maywood, and W. R. Livingston, secretary and treasurer.

Following the business meeting there was a banquet, at which good fellowship and enthusiasm for medical organization were in evidence. The retiring president, W. F. Scott, read a paper on "Treatment of Diphtheria," followed by a general discussion, and the following toasts were responded to:

**The Fraternal Spirit**....F. H. Bates, Elmhurst  
**Medicine** .....Arthur Loewy, Oak Park  
**Medical Organization** .....

.....W. R. Livingston, Maywood

A vote of thanks was given the retiring officers for work done in arousing enthusiasm among the members of the profession of this district. W. R. Livingston, Official Reporter.

### Marriages, Deaths and Changes of Address.

#### MARRIAGES.

Stephen V. Balderston of Evanston and Miss Eliz. Thompson, Old Point Comfort, Va., Jan. 5, 1903.

V. J. Cohenour, Joliet, and Miss Belle Harbour of Rosemond, Jan. 7, 1903.

L. F. Curtis, Elkhart, and Miss Mary F. Kennedy, Chicago, Jan. 1, 1903.

P. S. Doane and Miss Helen Pullman Stewart, Chicago, Jan. 1, 1903.

Herman Durand Peterson to Miss Marie Louise Freeman, both of Chicago, Jan. 14, 1903.

Harrison C. Hopper, Galesburg, and Miss C. VanRavenswaay, Dec. 29, 1902.

Edw. E. Moore and Miss Ida Morley, Chicago, Dec. 13, 1902.

Frank North, Taylorville and Miss \_\_\_\_\_ Bacon, Atlanta, Dec. 30, 1902.

William Rupp and Miss Eleanor M. Turner, Chicago, Dec. 24, 1902.

Paul S. Scholes and Miss Bertha Chapman, Oct. 15, 1902.

Alfred J. Stocker, Erie, O., and Miss Nettie Stratton, Dec. 4, 1902.

Harry W. Wardle and Miss Helen Price, Chicago, Dec. 25, 1902.

Albert E. Wrixon of Chicago and Miss Olive Beaulieu, Appleton, Wis., Dec. 31, 1902.

#### DEATHS.

Betttersworth, A. P., formerly of Carlinville, at Los Angeles, Cal.

Dickerman, Edw. T., Chicago at Springfield, Jan. 23, 1903, age 35.

Douglas, Jas. R., Batchtown, Calhoun Co.

Hays, Jacob, Chicago, Jan. 2, 1903, age 62.

Hoover, Chas. I., Ottawa.

Johnson Henry, former resident of Buford, Macoupin county, died in Arkansas, aged 50.

Jordan, N. F., Bloomington, Dec. 28, 1902, age 38.

Kohl, Julius, Belleville, age 65, January \_\_\_\_\_

Murphy, John, Peoria, Jan. 21, 1903, age 86.  
 Shutt, Margaret T., Springfield, Jan. 24, 1903, age 35.  
 Sibley, C. W., Fairfield, Jan. 13, 1903, age 64.  
 Tummerman, G. A., Chicago, Jan. 5, 1903.  
 Warren Watkins, Mt. Vernon, at Thomasville, Ga., Jan. 2, 1903, age 68.

## CHANGES OF ADDRESS.

## CHANGES FROM CHICAGO.

Cook, A. H., 234 Dearborn st. to Oak Park  
 Dalager, N. O., to Eagle Grove, Ia.  
 Heisz, E. J., 6118 Monroe ave. to Nora Springs, Iowa.  
 Lockwood, C. O., to Los Angeles Cal.  
 McAuley, H. H., 360 Erie st. to Giltedge, Mont.  
 McClure, Alberta, 6407 Lexington ave. to St. Paul, Minn.  
 Miller, A. Merrill, to Danville.  
 Nuckolls, Lillian J., to Missouri.  
 Ohlmacher, A. P., 2425 Dearborn st., to Galliopolis, O.  
 Platz, C. H., to Mt. Vernon, Iowa.  
 Warren, B. A., to Merrill, Wis.

## CHANGES TO CHICAGO.

Hultgen, J. F., Mt. Pleasant, Ia., to 5308 Bishop st.  
 Metcalf, C. F., Mt. Vernon, Iowa to Chicago.

## CHANGES IN CHICAGO.

Abell, Nathan W., 1753 Milwaukee ave., to 1242 N. California ave.  
 Allen, W. J., 1216 Milwaukee ave., to 1427 Roscoe st.  
 Balderston, S. Victor, 1578 Chicago ave., to 1518 Chicago ave.  
 Beck, C., 522 Dearborn ave., to 42 Roslyn Place, Lake View.  
 Coleman, W. F., 5148 Cornell ave., to 5235 Cornell ave.  
 Coy, W. F., 502 LaSalle ave., to Kingston ave.  
 Dowiat, N., to 723 W. 18th st.  
 Goetz, F. A., 150 Park st., to 1518 Milwaukee ave.  
 Halsanson, A., 6306 Halsted st., to 417, 31st st.  
 Hall, Geo. C., 5145 Armour st., to 5736 Rosalie Ct., Hyde Park.  
 Harrison, W. K., 30 Walton Pl., to 52 Walton st.  
 Holberg, Jno. E., 180 N. Halsted st., to 214 N. Curtis st.  
 Hollenbeck, F. D., 205 N. State st., to 183 Rush st.  
 Knudson, F. B., 235 N. Ashland ave., to 389 W. Erie st.  
 Kruager, G. E., 8947 Exchange ave., to 3616 Ellis ave.  
 Montgomery, W. A. D., 305 N. Clark st.  
 Niles, J. W., 420 LaSalle st., to 201 Winthrop ave.  
 Nelson, E., 153-92 st., South Chicago, to 175-92 st., North Chicago.  
 Phillips, Frank A., 1110 Washington Blvd., to 1660 Fulton st.  
 Schalek, A., 529 Garfield ave., to 59 S. Hermitage ave.  
 Stevenson, T. H., 608 E. Division st., to 34 Washington st.  
 Stone, C. D., 2220 Calumet ave., to 65 E. 22d st.  
 Stubs, R. S., 1310 Belmont ave., to 1454 Belmont ave.  
 Schlesinger, M. L., 549 N. Robey st., to 1301 Milwaukee ave.  
 Wenstrand, D. E. W., to 781 Monroe st.  
 Wills, Edw. F., 4571 Lake ave., to Kenwood Hotel.  
 Wood, G., 113 E. 35th st., to 4238 Vincennes ave.  
 Yarros, R. S., 22 Bellevue Pl., to 608 Division st.

## CHANGES FROM ILLINOIS.

Egbert, J. W., Minonk to Madras, India.  
 Patchen, C. C., Beardstown to Chandler, Okla.  
 Prentiss, —, Danville to Blakesburg, Ia.

## CHANGES IN ILLINOIS.

Albright, Adam C., Sibley to —  
 Bailey, M. R., Elliott to East Peoria.  
 Boot, G. W., Spencer, Ia., to Evanston.  
 Chrisman, W. D., Lafayette to —  
 Cothorn, W. R., Benson to —  
 Crain, L. F., Dongola to Pana.  
 Crain, M. M., Dongola to Pana.  
 Hart, J. D., Eddyville to Dongola.  
 Legier, John T., Keensburg to Carmi.  
 Metcalf, C. F., Crab Orchard, Neb., to Milan.  
 Schroeder, S. P., Hoyleton to Nashville.  
 Sims, John, Bluffs to Modesto.  
 Taylor, Walter S., returned from Colorado to Springfield and retired from practice.  
 Weems, C. M., Pepram to Griggsville.

## THE BEST ALKALINE WASH.

By W. Harper Sloan, M. D.

Chief Ear Department, Medico-Chirurgical College  
 Philadelphia, Pennsylvania.

There are many alkaline preparations on the market that are used daily with varied results in conditions where such a preparation is indicated. I have tried most of them in all conditions, and after an impartial trial, I am compelled to say that the preparation known as Glyco Thymoline, made by Kress & Owen Co., stands at the head of the list. Its formula is one that would commend its use, the ingredients being of an antiseptic and non-irritating nature.

Having formed this opinion of Glyco Thymoline, I have concluded to report a few clinical cases where it has given me good results.

Case 1. M. L., age 23 years, came under my care suffering with a distressing case of Ozena. The turbinated bones on both sides of her nose presented a condition of marked atrophy; there was a complete loss of smell and taste and a formation of crusts in the nasal chamber; stench of same was foul. She complained of continual headache, and other symptoms of a depleted and run down system. I placed her on a tonic of Iron, Arsenic and Strychnia internally; locally I ordered the use of Glyco Thymoline in a Birmingham Douche three times a day, diluted. After a month's treatment the crusts had ceased to form, there was a complete restoration of taste and a slight return of smell, the general health was improved and the patient well pleased with results.

Case 2. C. A., age 8 years, came to me suffering with a severe Otorrhoea following Scarlet Fever. There was a muco-purulent discharge from both ears that rendered the child completely deaf; the auditory canal was excoriated and sore and the general health below par. I used Cod Liver Oil internally and syringed the ears three times a day with Glyco Thymoline. At the end of one month the discharge of pus had stopped, the hearing much improved and the child's general health very much better.

# The Illinois Medical Journal.

The Official Organ of The Illinois State Medical Society.

New Series, Vol. IV. }  
No. 10.

Springfield, Ill., March, 1903.

{ SUBSCRIPTION  
{ \$3.00 A YEAR.

## THE MANAGEMENT OF OUR CHARITY HOSPITALS.\*

BY DENSLOW LEWIS, M. D., CHICAGO.

In every civilized community the care of those unable to care for themselves devolves upon some constituted authority. The law provides, where pecuniary circumstances permit, that the family must care for its constituent parts and regulations exist looking towards the enforcement of this requirement in whole or in part as the court may decide, whenever the obligation is not assumed voluntarily.

Where there is no family, some authorized agent of the State or of one of its component parts must act *in loco parentis* and proper provision must be made for the care of the dependent. The law in Illinois provides for township or county organization as each county may elect. In 19 out of 102 counties there is no township organization and in that portion of Cook County represented by the city of Chicago the different townships have recently been abolished resulting in a large saving of expense. In townships, the supervisors are *ex-officio* overseers of the poor but where the population exceeds 4,000 the county may appoint an overseer. Where there is no township organization the board of county commissioners designate some justice of the peace or other person as overseer. In Cook County such person is known as the County Agent. The overseers are directed by statute to have care and oversight of those unable to earn a livelihood in consequence of any bodily infirmity, idiocy, lunacy or other unavoidable cause if such persons are not supported by relatives or in county poor houses. The overseers are empowered to let out support of the poor to some "moral and discreet householder" of the county. They are also required to give or cause to be given

such assistance as is deemed necessary to the non-resident sick or dead. The county board of commissioners has power to appoint a county physician and to prescribe his compensation and duties. The board may also allow money for the purpose of tuition for children in almshouses although such practice is deprecated by those best qualified to judge of its value and in its stead is advised the placing of these children in reputable homes or temporarily in special institutions.

Restricting this consideration to the State of Illinois, although many conditions instanced and methods in use apply equally well to other states and to some foreign countries, it is to be remarked that the movement of population has varied greatly in the different counties. For this reason the care of the poor both in health and disease must present marked differences in reference to locality. In Kendall county, for example, the poor are maintained by townships; in Pope county they are boarded at a private farm house; in Boone county a farmer living about nine miles from Belvidere contracts to provide for all homeless paupers for a compensation of \$950 per year, and in Gallatin county an average of six or seven paupers are boarded by a farmer near Omaha. In all other counties almshouses or poor farms exist where are collected all dependents and defectives not otherwise provided for and in some instances certain delinquents as well.

The United States provides for the incapacitated and disabled among our soldiers and sailors and institutions for their benefit exist in our midst. Certain nationalities—notably the Jews—and many religious denominations maintain institutions of different kinds which assist the country to a considerable extent in the care of the unfortunate classes. Private philanthropy also comes to our aid although not to the extent that is observed in England and some other European countries. Our medical

\*Read at the 52d Annual Meeting, Quincy, May 21, 1902.



schools, for the purpose of clinical instruction, relieve the body politic of the care of certain classes and the state itself maintain several institutions under the supervision of a Board of State Commissioners of Public Charities. This board, appointed by the Governor, consists of five members who serve for a period of five years without pay and a secretary who is the executive officer of the board. The board has charge of five insane asylums, located at Elgin, Kankakee, Jacksonville, Anna and Watertown, an asylum for the incurable insane at Peoria, an asylum for insane criminals at Chester, an institution for the education of the deaf and dumb and another for the education of the blind, both at Jacksonville, an asylum for feeble-minded children at Lincoln, a soldiers' and sailors' home at Quincy, a soldiers' orphans' home at Normal, a soldiers' widows' home at Wilmington, a charitable eye and ear infirmary at Chicago and a state home for juvenile female offenders at Geneva. The amount appropriated by the Forty-first General Assembly for the maintenance of these institutions for the last biennial period was \$4,350,161.12. The amount asked for from the Forty-second General Assembly for the next biennial period is \$4,944,534.92, which includes an appropriation of \$350,000 for the proposed colony for epileptics.

By legislative enactment in force July 1, 1899, the board is authorized to inspect and report on all associations having to do with the treatment and control of dependent, neglected and delinquent children. The associations which complied with the law and made a report to the board, as set forth in its last official publication, are: The American Home Finding Association of Chicago; the Association of Southern Illinois, located at Hoyleton; the Chicago Home for the Friendless; the Home for Destitute Crippled Children at Chicago; the Girls' Industrial Home at Bloomington; the Illinois Charitable Relief Corps, Illinois Children's Home and Aid Society and Illinois Humane Society, all of Chicago; the Illinois Industrial School for Girls of Evanston; the Illinois Manual Training School Farm of Glenwood; the Peoria County Industrial

School for Girls and Home of Blessing; the St. Joseph's Providence Orphan Asylum of Chicago; the St. Mary's Training School for Boys at Fechanville; the St. Vincent's Infant Asylum of Chicago, and the Chicago Visitation and Aid Society. There are, moreover, in Illinois, two penitentiaries, at Joliet and Chester, respectively, and a reformatory at Pontiac. In addition every county except Woodford has a jail.

Thus it is seen that Illinois does well in the attempt to provide suitable accommodation for a large proportion of our pauper class and it is gratifying to be able to say that the administration of the institutions is in many respects most admirable. If the provision is at times inadequate, if bed bugs are found occasionally in some of the jails and almshouses, it must be remembered that we are not yet perfect in our development and that our civilization is still young. For this reason, when we consider the care of the sick poor in many of our institutions and under the existing township and county organizations it is not surprising to find that much improvement is possible. In the last report of the Board of State Commissioners of Public Charities, Oct. 1, 1900, under the heading "Provision for the Sick," and referring to almshouses, the answer is "none" for 64 counties, "good" for 23, "fair" for 5, "incomplete" for 1, "insufficient" for 1, "partial" for 2, "excellent" for St. Clair and "complete" for Cook county, while for four counties there is no report. In all counties except Cook, where physicians are on the premises, medical attendance is on call.

The salary paid the medical attendant who is often the county physician varies from \$7,920 in Cook, which employs several, \$2,000 in Peoria, \$600 in Adams, Fulton, Macon and Vermilion, to \$40 in Franklin. Eleven counties have county physicians without a stated salary, while eight counties have no physicians under contract. It is not to be inferred that in these latter counties the sick poor are neglected. With perhaps annually only a dozen or twenty individuals who require medical attendance, the overseers can more conveniently and more economically call on different physicians

rather than contract with any one to have charge throughout the county. In the counties where no stated salary is paid it is probably cheaper to pay the county physician for the actual services rendered. It is customary in many counties for the overseers to advertise for bids and to award the contract for the year to the lowest bidder. As far as I can learn the endeavor is made to secure competent men and in certain instances men who proved undesirable were discharged and others appointed. Complaint has been made that this method of appointment is undignified and that the physician is unethical who will sell his skill for an insignificant amount. I cannot concur in this statement. There is a value in such an appointment besides the salary that is paid or good practitioners would not be so anxious to secure these positions. As long as competent and faithful service is rendered it is, to my mind, the duty of the overseers to incur as small an expense as possible. It must, moreover, be understood that the salary and the prestige incident to the office are not the only emoluments, although at the salary stated, or at a reduced rate, the incumbent is expected to furnish medicines and attend a few obstetric cases. Surgical cases occur and in most counties operative treatment is fairly well paid for. At a recent meeting of a county society which I attended one practitioner reported 47 cases of empyema, many of them occurring among paupers. It will thus be seen that the opportunity may exist for adding somewhat to the county physician's income besides furnishing him with an extensive surgical experience.

It must be realized that conditions in the country districts are very different from those observed in large cities. In Iroquois county, for example, I am told that there never has been but one delirium tremens patient and he probably strayed in from Cook county. Typhoid fever practically never occurs and pneumonia is rare. Serious accidents are unusual among the paupers of country districts and epidemic diseases occur but at infrequent intervals. Under these conditions it is of course unnecessary to provide extensive hospital accommodation

in connection with the jails or almshouses. At the same time there will occasionally be a case requiring skillful and perhaps special attention and the interests of humanity demand that suitable provision be made in one way or another for the care of such cases. It is distressing, for instance, to read about one prisoner in the DeWitt county jail who had lost the sight of an eye while incarcerated and will surely lose the sight of the other unless he is properly treated outside of the horrible old hole that is still used as a jail. In Gallatin county the jail is described as a rotten, unsightly old building, inside and out, totally unfit for human habitation and full of foul odors and vermin. In Hamilton county the building is a disgrace to the county. It is dilapidated, poorly arranged, foul and unhealthy. The Brown county jail is old, dirty and totally unfit for occupation. In the Madison county jail are two dungeons which it is inhuman to use as there is no chance for air except through a few three-sixteenths of an inch perforations in the door. In Pulaski county all prisoners, black and white, are crowded into an unpartitioned cage which is densely populated with vermin. In Scott county the jail is in bad repair and so dark and damp that it is injurious to the health of the prisoners. It has been condemned by almost every grand jury that has met in the past fifteen years, yet nothing is done to improve it. Many jails, however, are in fine condition. In White-side county there is a padded cell for the insane but it is seldom used as no insane are kept there longer than time for the next train to the hospital. In Kankakee county the jail cost \$22,000 and has all modern conveniences. There are six separate cells for women and four for juveniles; there are also male and female hospital wards. When it is realized that there are some 15,000 inmates of our jails each year it becomes evident that proper sanitation is a matter of importance.

The population of our almshouses is about 36,000 annually. Many of these institutions are admirably adapted for the purposes for which they are intended. Some of them are a disgrace to our civilization. Nearly

all of them need a hospital ward and a separate building for contagious diseases as well as adequate provision for the control of the violent. Several of the superintendents are ignorant and brutal farmers utterly unfit by nature and training to attempt to care for the unfortunate. The Jackson county almshouse is described as a more suitable habitation for the rats, mice, bed bugs and other vermin that inhabit it than for the unfortunate human inmates. In the Pulaski county almshouse an idiotic girl about twenty years of age is reported to be confined in a filthy room with neither light nor air, a close shutter without ventilation covering the window. Instead of a bed she has a pen on the floor which is too dirty for a hog to thrive in. In Wayne county the insane are reported to be kept like so many wild beasts. They are quartered in a one-story narrow building fronting north with windows in the east and west sides which have no shades or screens and the hot sun shines in on the inmates from morning until night, while the flies swarm over them in countless thousands. Most of them have no beds or bedding in the iron-barred cages in which they are constantly confined and some are only partially clothed, two of the men having nothing but short shirts. Their persons and dens were filthy and the stench from them was sickening. In the Williamson county almshouse was a man over sixty years of age who had been there six months with a broken leg which he had the misfortune to break a second time. The physicians refused to treat him unless the county would guarantee to pay \$25 for an operation. In Edgar county, in addition to an exceptional equipment for the care of paupers, there has been built at a cost of \$10,000 an orphans' home for unprotected children for which is appropriated annually \$1,000, the necessary balance being raised by private subscription. In Jo Daviess county a half-breed Indian woman has been a county charge for fifty-five years.

In cities and many of the larger towns of the state additional provisions are made for the care of the poor who may be sick or injured while the state institutions already mentioned do good work as far as

their facilities will permit for special classes of dependents, defectives and delinquents. The growth of Illinois, especially certain portions of the state, has been rapid and although the amount appropriated at each session of the legislature is large, although many municipalities expend large amounts each year and private philanthropy does much for the benefit of suffering humanity, there are still many unfortunates who fail to receive that care which an enlightened humanitarianism would wish to provide. The hospitals and sanitarium established in cities of more than 9,000 inhabitants are located as follows: In Alton 1, in Aurora 2, in Belleville 2, in Bloomington 3, in Cairo 2, in Champaign 1, in Chicago 50, in Danville 3, in Decatur 1, in East St. Louis 2, in Elgin 1, in Evanston 2, in Freeport 1, in Galesburg 2, in Jacksonville 3, in Joliet 2, in Kankakee 1, in LaSalle 1, in Moline 1, in Ottawa 1, in Peoria 3, in Quincy 2, in Rockford 2, in Rock Island 1, in Springfield 4, in Streator 1, in Waukegan 1. Of course there are other institutions in these cities and in the smaller ones, but their plan of organization and their administration differ but slightly if at all from the methods elsewhere in use. Many of these hospitals are under denominational control, such as the Alexian Brothers, the Sisters of St. Francis, or the Norwegian Deaconesses. Others are private institutions—homes, sanitarium—the property of individual practitioners—and some are governmental establishments, e. g., the marine hospitals at Cairo and Chicago and the Danville branch of the National Military Hospital. Some are devoted to special purposes, conducted for certain nationalities or in the interest of certain sects, medical schools or corporations. I venture to say that not one of them would refuse admission to a serious emergency case for a brief period and I know that many of them design to accommodate certain worthy charity cases to at least a limited extent while many of them exist exclusively for the scientific care of the sick poor.

It is of interest to describe certain institutions somewhat in detail. The John Stuart Ryburn Memorial Hospital of Ot-



tawa was established in 1895, by the widow of a physician. It now has an endowment fund of \$40,000, the income of which goes to sustain it. It has received several legacies and many public-spirited citizens by various means have contributed to its support. Three years ago our permanent secretary had charge of a ball which cleared over \$1,400 for its benefit. The board of aldermen has charge so far as furnishing supplies is concerned; a board of five trustees is appointed by the mayor and there is also a board of management which consists of several women. The health officer, by ordinance, is made physician in charge but every physician in good standing is on the staff and may treat his patients in the hospital as if they were in their own homes. If a patient cannot pay a dollar a day for his bed he pays half price if he can afford it or nothing at all, provided his physician who understands his circumstances certifies to his financial disability. The number of inmates the past year has averaged ten a day.

The Galesburg hospital received \$100 a month from the city for the care of its poor who need hospital treatment. The commissioners of Knox county pay for indigent patients sent to the hospital from outside the city. Twenty-three patients can be accommodated and about five per cent of the work done, including the city cases, is charity. The city physician has charge of the city cases, the staff cares for other patients who have no physician, but any reputable practitioner of the county may send in patients excepting that chronic cases may remain not to exceed three months.

St. Elizabeth's Hospital of Danville is in charge of the Franciscan Sisters of the Sacred Heart. The staff consists of four physicians, four surgeons, one oculist and aurist and four visiting physicians. Charity patients are admitted without limit as far as the accommodation for sixty or seventy will permit. Each member of the staff serves for two months at a time and cares for all charity cases assigned to him. Any reputable physician may make use of the hospital and operating room for his patients. The number of inmates last year was 423.

Vermilion county since 1892 has also had a county hospital under the control of a board of twenty-four trustees, at least ten of whom are selected from Danville township and the others, one each from the other townships in the county. In June, 1899, all indebtedness was paid off and some additions and improvements were made. The association solicits subscriptions and endowments. Seventy-two persons who have given \$100 each are life members of the association. The hospital admits private patients who pay \$5 to \$12 a week and its charity cases are county charges paid for by the county commissioners at \$4 per week. Thirty-seven inmates can be accommodated and some 300 patients received treatment during the year. The staff consists of seven physicians, six surgeons and one aurist and oculist. There is also a homeopathic staff of five practitioners. The service is divided into terms of two months each.

St. John's Hospital at Springfield has branches at Lincoln, Decatur, Effingham, Belleville, Strcator and Litchfield, all of which are in charge of Sisters of St. Francis. They received, during the year, 7,064 patients of whom 424 were charity cases. These latter are paid for by the city or county authorities at the rate of \$3 or \$4 a week. The staff in the Springfield institution consists of two physicians, two surgeons, two aurists, oculists and rhinolaryngists and one pathologist. The hospital does not receive syphilitic, alcoholic, contagious or mental cases or children under two years of age. The members of the staff alternate monthly in their service in the charity wards.

Blessing hospital of Quincy accommodates between 45 and 50 patients who pay from \$5 a week up, if private cases, and for whom the county pays \$3 a week for pauper cases requiring hospital treatment. The hospital is the property of an association composed of an equal number of men and women members, not exceeding fifty of each sex. The women pay \$5 a year and the men pay \$10; they hold their membership as long as they pay their annual dues. From this membership are elected twelve men who constitute the

board of trustees and from the women, who are the executive committee, is elected a board of managers. Medical service is rendered by a staff, not exceeding twenty in number, holding office during the pleasure of the trustees. The staff subdivides the work and fixes the term of service, but rotation is insured by providing that no one physician shall hold a position for two consecutive terms. Other physicians may place pay patients in the hospital; all classes of cases are admitted except contagious diseases and chronic cases lasting more than two or three months.

Quincy also has St. Mary's Hospital, founded in 1866 by the Sisters of the Poor of St. Francis and recently improved by a large extension so that it now accommodates 200 inmates. The staff is appointed by the Sister Superior and each physician has charge of a certain section of the hospital which he visits once or twice a day: All patients who present themselves are received, except obstetric, venereal, contagious and insane cases. Those who can do so are expected to pay for hospital and medical care, but all are admitted regardless of financial ability. Once a month the charity cases are utilized for the purpose of clinical instruction at the meeting of the Adams County Medical Society.

The Franciscan Sisters have another hospital of 70 beds at LaSalle. Here there is no medical staff. Ten years ago it was decided that the hospital should be open to all medical men of good standing and the plan has worked well. The local zinc companies have established fine operating rooms and have contributed a microscope, an X-ray machine and \$2,000 worth of surgical instruments. Charity cases sent in by local physicians are admitted free of charge. The field of usefulness of this hospital extends beyond the borders of the county in which it is situated. Pauper cases requiring surgical treatment are received from adjoining counties on payment by the supervisors of a nominal amount.

These Sisters maintain another hospital at Evanston with provision for 30 inmates and St. Anthony's Hospital at Rockford, which has 25 beds. Charity cases are ad-

mitted, as far as the accommodations permit, on the order of local physicians. Geneseo has recently established a small hospital under the supervision of the city council. Cottage Hospital at Peoria has 125 beds of which about 12 per cent are free. The charity cases are cared for by subdivisions of the staff who alternate in service each month.

It is perhaps unnecessary to speak further of the other hospitals throughout the state. They differ but little in essentials as regards management and method from those already described. The great charity hospital of the state is of course the Cook County Hospital, which is, on account of its location in the city of Chicago, one of the most important institutions of its kind in the United States. It is exclusively a charity hospital under the control of the county commissioners. As these officials are elected once in two years the superintendent, who is called the warden, may be changed at each biennial period. As a matter of fact it is rare for him to remain to exceed four years. The vicissitudes of politics make improbable the continuance in office of the commissioners themselves and especially of the president of the board, who is in effect the mayor of the county with appointive power. Cook county also maintains an almshouse, called an infirmary, an insane asylum and a hospital for consumptives which probably will soon be abandoned. These institutions are located at Dunning, some ten miles northwest of Chicago. They are all highly commended by the visitors of the board of state commissioners of public charities. There is also in the county hospital grounds a detention hospital in charge of the county physician, but under the management and control of the warden of the county hospital. The county agent cares for the outdoor poor in the First district, which consists of the city of Chicago, while the supervisors of the thirty townships, which comprise the county commissioners' district, act as elsewhere throughout the state where township organization exists.

It were perhaps interesting to consider how defects in the administration of all charitable institutions in the State might

be remedied by a change in method, a more equitable apportionment of the obligation forced upon each community or a radical departure from the system of management that now exists. If we had to start over again there is no doubt much improvement might be suggested. I think more good will result if we accept conditions as we find them and seek to perfect rather than to change.

In Cook county the commissioners arrange for the medical service at the different institutions. They appoint usually a "business man" in charge for it is thought to be of chief importance to make sure that affairs are conducted economically and honestly. At Dunning are stationed several paid resident physicians, a proportion of them being women in deference to the demands of certain women's clubs. It is thought inadvisable—the claim has been made that it was indecent—to have men in charge of the women in the insane asylum. At odd times during the past fifteen years attempts have been made to improve the medical service by the appointment of an attending or consulting officer or staff. On one occasion, some years ago, after a newspaper scandal in reference to the alleged mal-treatment of an inmate, I had the honor of serving as the advisory officer to the insane asylum. I accepted this position under protest for my experience as regards the care of the insane is extremely limited. One distinguished neurologist is said to have refused to serve unless he was paid and another would not make recommendations unless he had the power to enforce them. Under these conditions I accepted the appointment at the solicitation of the president of the board of commissioners for I felt that the opportunity that had been given me during many years to gain experience at the county hospital made it imperative for me to serve the county as best I could in any capacity that seemed advisable.

The different staffs that have served at Dunning have not all been a success. It must be remembered that it takes half a day to visit the institutions from Chicago, and costs at least twenty cents. The resi-

dent physicians have not always felt that they were in any way under the control of the staff. Many of them have resented the idea that a member of the staff should operate and, moreover, the facilities were restricted for aseptic procedures and approved surgical treatment. The internalists on the staff found difficulty in locating interesting and important cases so that much time was wasted. The distance is so great that few students would visit the institutions even had they been invited and no arrangements existed for holding amphitheatre or bed-side clinics. The practitioners of the county who were not on the staff felt they intruded unless they accompanied a staff member and, for these reasons, much valuable clinical material has been wasted and many an opportunity for instruction has been neglected.

At rare intervals—once or twice a year—some neurologist would take out a class of students and demonstrate different types of insanity while the superintendent would think he was fully discharging his duty if the inmates were kept clean, well-fed and in order, a task which, on account of the over-crowding, was often difficult. Since the establishment of the hospital for consumptives some members of the staff have been assiduous in their attention but the building is poorly adapted to the care of these cases and the facilities for rational treatment are lacking.

About a year and a half ago I suggested to the authorities that the staff of the county hospital become the attending staff at the Dunning institutions. I advised that internes be chosen by competitive examination and that they rotate in service so they might gain experience in the three institutions. I further suggested that an amphitheatre be erected for clinical instruction, that a morgue and laboratory be installed, that a modern operating room be equipped with an emergency ward in connection and that arrangements be made to keep a proper record of the work done. It was realized that many chronic cases required the most skillful treatment which could only be given by men of experience. It was understood that men of this kind could not—and an



observation of fifteen years had convinced me that they would not—give the patients the requisite consideration unless the work was systematized and there was an adequate incentive. The county could not pay for services of this kind but it was hoped, when proper facilities for giving clinical instruction were provided, when trained internes could sort out and prepare the material, the eminent men of the profession of Chicago, many of whom are connected with medical colleges, would appreciate the opportunity thus afforded for giving instruction, and many students and practitioners might benefit. In this way alone it seemed to me, and my conviction now is stronger than ever, can these derelicts of society receive consistent treatment at the hands of specialists.

The plan suggested was approved and carried out to a certain extent. Internes were chosen and volunteers from the hospital staff were called for. The superintendent at Dunning acquiesced in the scheme and the president of the board of commissioners was convinced of its desirability. The question of money intervened. The tax was paid in, the budget had been made up, there was no available fund upon which to draw for the proposed improvements. In the meantime the internes revolted and resigned. They had expected to profit by the counsel of the attending staff; they anticipated a surgical service but little inferior to that of the hospital; the old conditions were restored.

More recently, in consequence of these circumstances, an investigation was ordered. The final report of the committee appointed has not yet been made but as a result of their deliberations a medical director is now installed. This is apparently a step in the right direction but it is not enough. No one man can be competent to perform prostatectomies and treat the insane. Some plan similar to the one I proposed will, I am sure, be necessary. It will not be feasible until the professorial idea is more completely abandoned. The surgeon, while taking all proper advantage of the prestige that comes to him from his erudition and skill, should understand that his duty is to teach

others to operate and not merely to impress his students with a realization of his superiority. The internalist, while appropriating all credit for his perspicacity and extensive knowledge, should remember that the lives of countless thousands are potentially in his hands. He must see to it that his students learn to treat disease by proper clinical instruction nor must he be too anxious by ex cathedra statements to demonstrate his infallibility. Moreover the men of eminence in the profession must not be selfish or jealous. In a few years they will pass away and others will take their place. Their duty to humanity requires that they give the younger men a chance, that they train them for work in the future and encourage them in their ambition to excel.

The first year I became a member of the Cook County Hospital staff a gigantic newspaper scandal had precipitated an investigation as a result of which certain commissioners were fined, others were sent to the penitentiary and the warden became a fugitive from justice. This investigation applied to the staff only to the extent in which they were supposed to have been "boodlers" and had no reference to their professional conduct. For some years afterwards all was lovely as a summer's dream. The staff was small, it was subdivided so that each man received an adequate service, and, with the exception of an occasional attempt on the part of certain members to dislodge the homeopaths, all was harmony. In time the staff increased in number so that the division of the service gave each member but a few weeks' period of actual work during the year. Homeopaths have been on the staff for years, but their staff also increased in number, and, in addition, an eclectic staff was established. As a matter of abstract justice it must be acknowledged that as taxpayers and residents of the county they possess the right of representation. The physio-medicists also claimed recognition two years ago. When it was shown that there were but twenty of them in the county it became evident that their claim for representation was absurd. What the osteopaths and Christian Scientists will do in the fu-

ture I cannot say. It is known that they have votes and it is to be remembered that the revolutionary war was the outcome of the protest against taxation without representation.

Some years ago the staff was divided. About fourteen members constituted the attending staff and some sixty individuals were appointed on what was known as the advisory staff.

It soon became evident that my advice on the part of this staff was unwelcome. A few members were permitted by the attending staff to hold weekly clinics, but the greater number became mere figure heads whose connection with the institution was purely ornamental. Of course this arrangement did not continue. There were too many men anxious to enjoy the experience and prestige of the hospital appointment. Both staffs increased in number and an increasing number of the advisory staff were permitted privileges very much to the disgust and discomfiture of certain members of the attending staff.

On January 28, 1901, the present staffs were appointed. They consist, besides a homeopathic staff of 17 members and an eclectic staff of 16 members, of an attending staff of about 60 members, subdivided into surgeons, physicians, pathologists, dermatologists, obstetricians, pediatricists, ophthalmologists and aurists, neurologists and a dentist. An associate staff of 23 was also appointed and provision was made for an advisory staff, but as yet no members of that staff have been nominated. Both the attending and associate staffs have subsequently been enlarged.

On April 25, 1901, in consequence of certain public allegations of mal-treatment on the part of a former patient of the hospital an investigation was ordered. The committee appointed for this purpose reported May 13, 1901, and, as a result of recommendations made at that time, a new warden was appointed and there was created a special committee on rules consisting of three commissioners. This special committee reported November 18, 1901, and new rules were adopted.

The present warden, by wide experience, has gained a clear insight into the needs

and conditions of the county. His exceptional ability and tireless energy have been publicly demonstrated in many important respects and his administration of the county hospital bids fair to add greatly to the effectiveness of the institution. The president of the Board of Cook County Commissioners is a gentleman of education and erudition whose humanitarian instincts actuate him in securing proper care of the sick poor to the fullest possible extent. He is alive to the responsibilities of his position and, thanks to his hearty co-operation with the attending staff, many improvements have been possible in the equipment and management of the hospital. Unfortunately, for the institution, both these gentlemen have been nominated for higher county offices, and within a few months they will undoubtedly be called to new fields of usefulness, while the management of the hospital will be entrusted to other hands.

After the election in November new staffs will be appointed and undoubtedly many new methods of management will be introduced. It is probable from time to time new charges of mal-treatment will be made and new investigations will be ordered. An experience of fifteen years justifies me in claiming much improvement as to management and service while an observation of the workings of many of the larger hospitals of the world permits me to assert very positively that in general effectiveness the Cook county hospital compares favorably with all others wherever located. It can, however, be made better and, since the recommendations I have to make apply to some extent to all hospitals throughout the State, it is perhaps not without interest to consider certain general propositions which, in my judgment, will materially add to the usefulness of all institutions having to do with the care of those in need of professional attention.

A charity hospital is ostensibly and primarily for the benefit of paupers but in effect it must be more. If it is the only hospital in a locality it must provide accommodations for others as well for it is known that many modern operative proced-

nres are conducted more safely in a hospital than in the wealthiest home. Moreover, our charity hospitals should be open to the paupers of adjacent neighborhoods who may require special treatment. There might advantageously be established a reciprocity between counties whereby cases requiring hospital treatment could be sent to counties that support a hospital. I am sure the staff of Cook county hospital would welcome all operative cases and it is certain many of our convalescent and debilitated cases would be benefitted by a visit to country districts. The man with the broken leg in the Williamson county almshouse may be assured of surgical attention in Cook county hospital without any thought of a fee. The Chicago maternities would gladly receive all obstetric cases and many nursing mothers and sickly infants could advantageously be sent away from the city. The charity hospital must also accommodate persons of moderate means in some instances. It is evident the small tradesman or the workingman may be in need of a major operation and at times it may be impossible for him to pay even the small fee demanded for a bed by some of our post-graduate or denominational institutions.

If the jails cannot fit up at least one room for the care of those needing medical or surgical aid provision for this class of cases should be made in connection with almshouses or hospitals. In the larger cities a portion of the hospital should be made into a prison as is done in some eastern cities. The injured prisoner can thus receive proper surgical aid without the possibility of escape. It is outrageous that a man charged with swindling, like the man in the DeWitt county jail, should lose one eye for want of treatment when, if prison wards were established, reciprocity among prisoners might be inaugurated.

While considering the exchange of patients I beg to say that as regards the tuberculous the reciprocity should be inter-state in character. The necessity of a plentiful supply of nutritious food in the treatment of this class of cases makes their care a matter of considerable expense which would justify the outlay for transportation. The advan-

tage of suitable climatic environment is admitted in many instances and I believe it is feasible for us to operate on many paupers of Arizona and Colorado if the citizens of these states will provide for some of our cases of tuberculosis.

Concerning the admission of cases to a charity hospital it is conceded that the acutely ill, the seriously injured and those patients requiring surgical treatment may properly be received. As regards chronic cases, it should be remembered that in many instances—as in certain forms of heart disease—treatment effects an amelioration of distressing symptoms and puts many a bed-ridden man on his feet. The possibility of improvement under treatment should be the criterion of admission of chronic cases. I believe it to be of the greatest importance to admit inebriates. These unfortunates are especially liable to accident and disease incident to exposure. Moreover, as a matter of general knowledge, it is realized that many sufferers from epilepsy, apoplexy, mild insanity or heart or kidney disease may be found unconscious in the public street as well as many a victim of accident, the sandbag or other form of assault. In these cases it is too often the custom of some kind-hearted but injudicious passerby to administer whisky. Under these conditions it is no wonder that the average policeman makes a diagnosis of alcoholism and as an admitted fact many cases of this kind have died from want of professional care. Of course, special quarters should be provided for the inebriates so that other inmates may not be disturbed. In Bellevue hospital of New York there are two pavilions—one for each sex. It was of interest to note, when I visited this hospital last February, that females were kept in separate rooms and the males in one large ward. I was told by the superintendent that many of the men would suicide if left free from surveillance.

In the admission of these cases and in all cases where there is an external traumatism, there should be taken down an accurate description of all marks of violence that are discoverable. This description should be certified to by the policeman or other person who brings the patient to the hospital. If



other injury occurs while the patient is under treatment it should be immediately recorded and certified to by some person in charge. A record of this kind is of value in preserving an accurate history of the case and if charges of mal-treatment or abuse are made it permits of an official refutation.

If there are many children they should be lodged in a separate pavilion if possible apart from the hospital building. Their ward in any event should be on the ground floor so that in suitable weather the little patients may get out of doors.

Isolation wards for contagious diseases should be provided to the extent that is necessary. In Buda-Pesth there are nine separate buildings and in London I saw 600 scarlet fever patients in one large ward. These wards or building should be suitably appointed for, in the interests of the public health, it is desirable that isolation be secured in every case. Many a resident of a hotel or apartment building would gladly avail himself of a well equipped hospital of this kind and I predict that in Chicago before many years there will be established a private hospital for the treatment of this class of cases. A room with a glass door should be provided—a sort of observation room. This will permit the exhibition of the characteristic lesions to students without danger of contagion.

A separate building should be erected for skin and venereal cases. The herding together of these unfortunates is a source of danger to many of them as well as to the community at large. Proper provision for segregation should be maintained and a suitable hydropathic equipment should be installed to facilitate the scientific treatment of these cases. I have recommended to the Cook county commissioners the erection of a three-story building for this purpose and for the use of the county agent and within a year I have reason to believe such a building will be found on our hospital grounds.

As far as the assignment of patients is concerned it is self-evident that absolute fairness should prevail. With an attending staff of sixty practitioners it is apparent there must be a great disparity as regards age, experience and ability. Nevertheless

all are members of the same staff with equal rights and privileges which should be maintained. A spirit of harmony should exist and all should work together in the cause of humanity for the benefit of the unfortunates who cannot choose their own medical adviser.

I may say here that none of us know very much when we appreciate all there is to know. The members of the staff should realize that the patients under their care are not their exclusive property and that they themselves are not the only ones who may profit by the opportunity that they enjoy. The medical profession is a liberal profession and it is the duty of those favored by hospital appointment to seek to diffuse the knowledge they may have gained by imparting knowledge to others.

Consider, if you please, a manufacturing district on one of the borders of the great city of Chicago. There are found there some practitioners of experience and ability who care for the superintendent's family and the families of the foremen and chief workmen. There are found also many practitioners who have secured a diploma while working their way through the medical school. They are perhaps Swedes, Bohemians, Poles or Norwegians. They have a license from the State Board of Health and are the equals of any one before the law. They care for the laboring man and his family. They must earn their living but they should be encouraged to learn more. We all should be encouraged to learn and for that reason education should be free and the clinical material at our Cook county hospital should be available for instruction. The practitioners of Cook county are taxpayers and they should be not only entitled to attend all clinics but specially invited to do so. Provision should be made to make notification in advance regarding the operations to be performed and the cases to be presented. If a member of the staff is to present several cases of diabetes, for example, due notification should be given so that our practitioner of the manufacturing district referred to, if interested in such cases, as he will be if he has such cases in his practice, may come to the hospital clinic, may

learn the plans of treatment recommended and thus humanity may be benefited.

Some months ago I had a case where a fracture of the skull had occurred. A man had thrown a brick at the patient and I trephined. A gray-headed doctor from Missouri asked the privilege of witnessing the operation which was granted. Some months afterwards this doctor wrote me that in his practice he had seen a man kicked in the forehead by a horse. He remembered what he had seen me do, he acknowledged that otherwise he would not have known what course to pursue, he operated and his patient lived.

With several thousand medical students in attendance at the different schools, with several thousand practitioners of Cook county, with a variable number of practitioners from other states who visit us for the purpose of adding to their knowledge, it becomes the duty of the attending staff to provide adequate clinical instruction for the benefit of all who wish to learn so that humanity may be the gainer.

All departments of our practice at the hospital should be utilized for purposes of clinical instruction. The obstetric work is of special importance for every young practitioner delivers women in the early years of his practice if he does anything. Moreover, his first case may be a serious one and his knowledge may determine the life of both mother and child. False modesty is absurd in this connection. The assertion that it is immodest to expose the female genitalia to men becomes laughable when no restriction is placed on showing chancres in male patients to women students. It is certainly most remarkable to think there is any immodesty in exposing the genitalia of old prostitutes.

For successful execution, organization and discipline are necessary. The president of an attending staff should be thoroughly imbued with a sense of the responsibility of his position; he should have the confidence of the trustees or commissioners and by observation and experience he should be well versed in the details of hospital management. He should be willing to give much

time and thought to routine matters and while appreciative of the interests of humanity and the reputation of the institution he should also realize the necessities of the profession and understand that the instruction of students and practitioners is a duty to society and eventually the greatest possible benefit to the community. While it is a position of honor, it should not be thoughtlessly bestowed upon a man simply because he is old and respected or has attained eminence in the profession. It offers an opportunity for work of the highest order which should not be neglected. It demands an exhibition of fairness and a proper regard for the rights of all which should be fearlessly maintained. The executive committee should be composed, not of the president's intimate friends, but of representatives of all different interests. There should be a division of the work, a constant oversight of the different departments, a watchful supervision of all the workings of the institution, a harmonious attempt to maintain the dignity and increase the effectiveness of the hospital.

As regards the internes, it is known that in many instances they are the best men of the graduating class. They seek hospital positions so they may gain experience and as far as it is compatible with the interests of the patients they should be encouraged. I have always claimed that if an interne operates under my direct supervision I am responsible and really I do the operation although he may handle the knife. I believe it is right that these young men should get some practical knowledge to supplement the knowledge gained in the schools which is too often theoretical and sometimes very uncertain theory at that. At the same time discipline must be maintained. The internes are not the ones who treat the patients subject to the counsel and advice of the staff. The staff members are the attendants and the internes are their assistants. This relationship should never be forgotten. While I believe that every member of the staff should assist the interne in every proper way in his power, to derive the greatest benefit from his service, there must be no misunderstanding as to the relative rank

of each. For the benefit of all and in the interests of good management, the authority of the attending staff must be cheerfully acknowledged and their orders implicitly executed.

The superintendent of a large charity hospital is not often a medical man for reasons that are not difficult to know. Physicians are rarely practical politicians who can deliver the goods. Consequently they cannot often expect to share in the division of the spoils. The position, however, is most honorable and the salary paid should be in some degree commensurate with the importance of the office. I regard it as comparing in dignity with the position of judge of the superior court, and the salary in each case should be the same. I was deputized some fourteen years ago to confer with the late Dr. John B. Hamilton in reference to his acceptance of the position. Had it been possible to pay an adequate salary and secure permanency in office, Cook county might have enjoyed the advantage of this eminent authority's wonderful administrative ability. Since it is a fact that the official in charge of most of our charity hospitals must be a "business man" it becomes necessary for the attending staff, through their organization, to keep him advised regarding professional matters. There should be no conflict between these authorities all of whom are appointed in the same manner. There can be no question as to the advisability of having matters relating to the treatment of the patients, the discipline of internes and nurses, the methods of clinical instruction and all purely technical matters left in the hands of the staff provided that body is duly organized and assumes its proper responsibility. The superintendent should see that all patients are properly treated but it is absurd for him to attempt to dictate the treatment. He should see that all operative cases receive attention but should he try to decide when and how the operation should be performed he exposes his ignorance and makes himself an object of ridicule. He should above all things be fair and eminently just. He should have no favorites on the staff for all members are appointed in the same manner and have identical privi-

leges. He should work in harmony with the staff as they should work with him.

An institution like a charity hospital is most useful in every community. When duly organized and properly managed the benefits it confers directly and indirectly are beyond number. The good work that is done by these institutions should be recognized and substantially appreciated. Our wealthy citizens should see in our charity hospitals worthy institutions deserving their serious consideration. Assistance to the cause of humanity in its practical application is a more enduring memorial than the founding of a library or the erection of any pillar of stone or bronze.

#### Discussion.

H. H. Hart, of Chicago: I have been intensely interested in Dr. Lewis' presentation of this subject, because for fifteen years I was one of the inspectors of the public institutions of this state. You are probably all acquainted with the recent investigations made by the Bureau of Charities of this State with reference to the condition of the inmates of the institutions at Dunning. That investigation showed that at least twenty-five per cent of the inmates of those institutions are non-residents. They do not belong to the State of Illinois, and are, therefore, not entitled to be taken care of by this state. The same is true to a large extent in institutions in other parts of the state, and especially in some of the hospitals for the insane where patients from all parts of the country are being cared for, and even from other countries. It is a well-known fact that many of the adjacent states send their insane, their paupers and their sick into Chicago to be taken care of by some of the city or county institutions. These institutions would rather take care of these men for the balance of their natural life than to pay their railroad fare to the place where they really belong. That may seem to be a strange state of affairs, but it is true nevertheless.

Some few states have framed laws for deporting non-resident insane patients and paupers. Minnesota has such a law, and I drew up the bill for that state. Out of two hundred insane patients, fifty were non-residents, coming from foreign countries. All of these were deported, and none ever came back. The various states and pauper patients very soon become acquainted with the existence of these laws, and refrain from attempting to enter institutions or hospitals of other states. This lessens the expense to the State, and distributes these patients in the proper way. I have been informed that a bill will be introduced in the next legislature to provide for such a system for the State of Illinois. The saving is



incalculable, and I hope that the physicians of this state will support such legislation.

**D. R. Brower, of Chicago:** The one thing that we need in all our institutions in the State of Illinois, although I do not see how you or I can adjust it, is that these institutions be washed free from all kinds of politics. There was a time in the history of this great commonwealth when there were no politics so far as the state institutions were concerned. These institutions were conducted for the sole benefit of the inmates, and not for the purpose of offering a reward to some individuals for political service rendered. Such a procedure is bound to interfere with the proper conduct of these institutions. The question now is, however, how to get back to the old state of affairs, when all these great institutions were free from political intrigue. Civil service may bring this about, but I am sure I do not know how it will be done. It seems to me that if we will all get together, in our respective communities, and exercise the power that we possess, and are so loth to use, a spirited public sentiment might be got up which would compel the politicians to divorce themselves from any connection with these great institutions, and thus carry us back to the time when the officers of these institutions were selected because of their peculiar fitness and not because of political favors shown. These officers ought to be retained there as long as they are working faithfully and in the interests of the institution and its inmates. I had a very pleasant visit recently at Elgin and Kankakee, and found them getting along about as well as could under the present system, but it is not a scientific system. Any legislation which would tend to remedy the existing evils is deserving of the hearty support of all the physicians in this state, and I for one, would heartily welcome any steps in this direction.

## THE CARE OF THE PERINEUM DURING LABOR AND THE PUERPERIUM, BASED ON A STUDY OF FIVE HUNDRED AND FOURTEEN CASES\*

BY EFFA V. DAVIS, M. D., CHICAGO.

In looking through the text-books on Obstetrics, one is impressed with the great number of methods outlined for preventing rupture of the perineum in labor. The many positions suggested for the obstetrician's hands, the division of opinion as to the position of the patient, and the various theories in regard to "support of the perineum," are bewildering to the beginner.

The various maneuvers outlined, resolve themselves into the following principles:

1. *Control of the expellant forces.*
2. *Directing the presenting part into and through the vulvar opening.*
3. *Manipulations of the perineum itself by the obstetrician to render relaxation or support.*

(1.) To control the expellant forces, various suggestions are offered as (a) directing the parturient to check or increase the voluntary expulsive efforts; (b) permitting her to cry out, or breathe rapidly through the mouth; placing her on the side to remove the force of gravity; (c) the use of chloroform—beginning its administration as soon as the presenting part touches the pelvic floor, or begins to bulge the perineum with each uterine contraction; (d) direct pressure on the head, or presenting part applied in such a way as to press the part back into the birth canal in the axis of the vagina and well under the pubic arch, thus removing the strain on the perineum and allowing the element of time to act in more perfectly preparing the elasticity of the soft parts.

This principal of applying counter-pressure to the presenting part, was advocated by Hohl and afterward taught by Olshausen. Various positions of the hands, fingers, thumbs and parturient patient have been advocated in applying this pressure. Hohl placed the patient on the back with the thumb anterior to the occiput and the index and middle fingers posterior, upon that portion of the head which lies nearest the commissure. The hand thus controls to some degree, flexion and extension, and the too rapid exit of the head. Olshausen has highly commended this maneuver.

Ritgen practiced lifting the head through the vulvar opening between pains, by an upward and forward pressure exerted by the tips of the fingers upon the perineum, behind the anus, close to the extremity of the coccyx. He practiced this method as early as 1856 (first published in the *Leipziger Klinik und Poliklinik* in 1867.)

This idea was modified by Olshausen and Ahlfeld by hooking the fingers through the rectum under the chin or in the mouth, and expressing the head between pains by

\*Read at the 52d Annual Meeting of the Illinois State Medical Society.

an upward and forward pressure. Olshausen also advocated the lateral position for the patient, as it relieved the force of gravity and gave the obstetrician a better view of the perineum.

(2.) In directing the presenting part through the vulvar opening, the short sub-occipito-bregmatic diameter of the head must be made to engage and pass the vulvar opening by keeping the head flexed sufficiently to permit the full escape of the occiput under the pubic arch before the sinciput passes the perineum—the lower part of the face is pressed upon through the rectum, or posterior portion of the perineum as before suggested by Ritgen, Olshausen and Ahlfeld, and the occiput held down by hooking the fingers of the same hand over it, or by placing the fingers of the disengaged hand passed between the thighs against the portion of the occiput already born, forcing it outward and the chin upward, at the same time crowding the whole head upward to fill the available space under the pubic arch.

Fasbender suggested a reverse position of the hand as described by Olshausen, the fingers of the right hand hooked over the occiput and the thumb far into the rectum. Flexion and extension can thus be controlled and expression effected by the thumb.

(3.) Manipulations of the perineum itself have been advocated to render it more elastic and to distribute the tension. Massage with fats before labor, the application of hot fomentations during labor, and the manual dilatation by introducing two fingers into the vagina and drawing the perineal structures outward, are methods commonly used. Goodell practiced drawing the perineum forward over the head toward the pubes by applying the left hand in such a way as to hook the first two fingers far into the rectum and the thumb over the occiput, thus drawing forward with the perineum the anal ring to utilize the elasticity of the former to its full degree and insure a complete dilatation of the vulvar opening.

Playfair applied the hand so as to push the perineal tissues over the head by applying the thumb and two fingers on either side

of the vulva with thumb pointing toward the pubes.

Dr. Garrigue takes the elongated head when molded to represent a cylinder. To pass an elastic ring easily, it must have its axis at right angles to the border of the ring. This cannot happen if the perineum be pushed up or back which displaces the posterior portion of the ring. Ramsbotham, Baudelocque, Cazeau, and many others have advocated direct pressure to the perineum by placing the palm of the hand over it and making pressure during the pain. The term "supporting the perineum," most often means nothing more than this. Mechanical devices have been suggested to take the place of manual support, such as a towel held in the hands of two assistants who make direct traction against the perineum during a contraction. One of the late journals contains an article advocating strips of adhesive plaster firmly applied around the body so as to cross the perineum and give a firm resistance to the on-coming head.

Episiotomy proposed by Ould in his Treatise on Midwifery, 1742, has also been a method calculated to preserve the structures from more serious injury.

Goodell in summing up the subject in his "Lessons in Gynecology," says: "One advocates pressure on the perineum with a folded napkin, another with an unfolded napkin, a third scouts all napkins, whether folded or unfolded. One plugs up the rectum, another empties it. The perineum is pushed forward by some, and backward by others; some place their hands transversely across the perineum, some longitudinally with fingers looking downward; some longitudinally with fingers looking upward; as runs the nursery rhyme, 'Simon says thumbs up! Simon says thumbs down!' and yet the perineum tears, and tear it will until woman becomes like the cherubs of the old masters—all wings and no body."

The per cent. of ruptures has been variously stated. Olshausen considered fifteen per cent. not too high for unavoidable laceration due to defective distensibility of the perineum and disproportionate size of the

child's head. In ten years' work in Halle, he gives 21.1 per cent. of ruptures for primipara and 4.7 per cent. in multipara. Winekel reports 115 in 1,011 deliveries; Hildebrandt, 7.5 per cent.; Schroeder, 34.5 per cent. for primipara—9 per cent. for multipara; Stevens, from Gny's Hospital Reports, 133 lacerations in 562 cases, or 23.66 per cent. Of the 133, 6 only were multipara; 76 were slight, requiring one or two stitches. All lacerations over one-half inch from the fourchette were counted. The text-books give 35 per cent. for primipara and 9 or 10 per cent. for multipara. The fourchette is nicked in about 60 per cent. of all primipara.

The elements involved in the production of lacerations are:

1. Disproportion between the head and the outlet.
2. Faulty position of the head bringing it through in its long diameter.
3. Straight sacrum and poorly developed birth canal.
4. Narrow pubic arch.
5. Tough, inelastic vulvar ring.
6. Powerful contractions forcing the head through before the structures have time to relax.
7. Unskillful use of obstetrical forceps.
8. Delay of the head on the perineum.
9. Administration of ergot.

In ten years of active obstetrical work, the writer has used the following precautions to prevent rupture:

All primipara and most multipara are placed in the left lateral position as soon as the presenting part reaches the pelvic floor, or begins to strain on the perineum.

Chloroform is administered at the same time to check violent efforts at expulsion. If the contractions are gentle, it is withheld. Ether is not rapid enough to be quite as useful. It must be given in larger quantities and for a longer time to give results.

Direct pressure applied to the head when it appears at the vulva—by the left hand slipped between the patient's thighs which are held apart by an assistant, or by a pillow rolled and placed between the knees. The

head is held back firmly yet permitting a slight advance at each contraction, and at the same time regulating flexion and extension somewhat. Hohl's position of the thumb and fingers is a good one and can be used with the patient on the side.

Pressure applied to the jaw and lower part of the child's face by the fingers of the right hand as taught by Ritgen—pressure being made through the posterior portion of the perineum back near the coccyx and directed upward and forward, carries the whole head snugly under the pubic arch and keeps the degree of extension or flexion just as desired to direct the occiput safely through the outlet, and allow the nape of the neck to lie under the pubic before the sinciput passes the perineum, which insures engagement of the suboccipito-bregmatic diameter in the diameter of the outlet; not the occipito-frontal which is much longer and apt to present when the above manipulations are not applied correctly.

The rectum has been used by the writer at times for this maneuver, but owing to the dangers of infection, one must hesitate before getting the thumb or fingers contaminated in this way. A bit of cotton wrapped around the fingers, wet in antiseptic solutions, can easily be discarded when they are removed, or loose-fitting rubber cots that can be slipped off by an assistant, are something of a safeguard. However, the object of rectal expression can be gained almost as well by Ritgen's method and it has the advantage of superior cleanliness. A thick pledget of cotton is placed lightly over the anal opening to gather up any discharges, and frequently changed between contractions. The patient is allowed to cry out at the final expulsive efforts and the exit of the head is accomplished between pains, rather than at the height of one.

Experience is required to be able to judge when to safely let the head pass. The extent of dilatation must be estimated, the fragile state of the perineal structures watched with a good light, and the head made to recede when the circulation in the same seems to be too much impeded. The head is lifted out with a slight rotary motion in



order to turn the nose and chin slightly away from the median line of the perineum, and directed always in the arc of the circle of Carus. The shoulders following are given equal attention, the body being lifted upward and the rotary motion assisted. The upper shoulder is allowed to come down and out first, if possible. As the head is about to emerge, the assistant separates the thighs more widely and the patient is rolled slightly toward the back, but not upon it.

There was a time when I did episiotomies occasionally, but I find as I practice more and more carefully, the above measures, the need of the maneuver seems to pass away till in the last five hundred and fourteen cases occurring in my out-clinic, neither my assistants nor myself have performed it once.

#### REPORT OF CASES.

The following eighteen cases of rupture occurred in the last five hundred and fourteen cases confined in my outobstetrical clinic carried on for the benefit of the students of Rush Medical College, in which I have been ably assisted by Drs. Elizabeth P. Hay and Julia D. Merrill.

1. L. P. Young primipara, delivered precipitately before the arrival of the attendant. Two stitches.
2. B. O'B. Multipara. Perineum the seat of scar from repair of former laceration. Student delivered under supervision. Two stitches.
3. R. L. Young primipara. Precipitate delivery before arrival of attendants. Four stitches.
4. O. H. Young primipara. Delivered before attendant reached bed side. Four stitches.
5. L. R. Multipara. Normal delivery. One stitch.
6. E. F. Multipara. Precipitate delivery before arrival of attendant. Three stitches.
7. M. C. Multipara. Normal delivery. Two stitches.
8. F. McC. Multipara. Student delivered under supervision. Three stitches.
9. G. B. Young primipara. Delivered by assistant. Four stitches.
10. P. Multipara. Precipitate birth. One stitch.
11. M. B. Young primipara. Student delivered under supervision. Two stitches.
12. M. H. II-para. Delivered by assistant. Two stitches.
13. E. W. Young primipara. Delivered by assistant. Two stitches.
14. K. M. Young primipara. Precipitate birth. Three stitches.
15. M. C. II-para. Perineum the seat of scar from flap operation for repair of perineum

ten months before labor. Large head. Forceps. Three stitches.

16. M. B. Young primipara. Precipitate birth before arrival of attendant. Two stitches.

17. H. S. Young primipara. Precipitate birth in hands of student before arrival of assistant. Two stitches.

18. R. D. II-para. Perineum the seat of scar from repair of former laceration. Student delivered under supervision. Three stitches.

Of the eighteen cases, nine were multipara. Such a preponderance was probably due to the fact that students were more often permitted to direct the head out in those cases than in primipara, and to the fact that three had former repairs leaving scar tissue for the head to overcome.

Of the primipara, six were delivered before we could offer assistance. No severe ruptures occurred—no complete lacerations have ever taken place in the clinic at any time. All ruptures of one-half inch or more, are repaired. Ten out of the eighteen had but one or two stitches and the most severe required but four.

The perineum is closely inspected after the third stage and the integrity of the perineal floor noted. The blood is sponged away and a strong light thrown on the parts to discover any trauma if present. Repair is made at once with silk worm gut, and the parts cleansed once or twice daily as thought necessary till the tenth day, when the stitches are removed.

These cases are in the care of visiting nurses who are in training with me. They are sent from case to case with antiseptic pads and proper equipment for giving external douches of bichloride of mercury solution 1 to 2000. The cases are not catheterized and the bowels are made to move on the morning of the third day, and every second day thereafter.

There is union by first intention in a large proportion of the cases, which may seem almost incredible when we stop to consider that these cases are in the poorest homes in some of the worst quarters of our city, and are left to the care of their neighbors and relatives through the greater part of the day.

#### BIBLIOGRAPHY.

1. Olshausen—"Ueber Dammverletzung und Dammschutz." Volkmann's Samml. Klin. Vortr.," No. 41, p. 360.

2. Ritgen—Ibidem.
3. Ahlfeld—Das Dammschutz Verfahren nach Ritgen." Arch. f. Gynak. VI. p. 210.
4. Playfair—Text-book.
5. Stevens—Guy's Hospital Reports, London, 1896. Vol. II. p. 113.
6. Parvin—"Care of the Perineum," Trans. of Am. Gyn. So. 1882, Vol. VII. p. 145.
7. Reamy—"Protection of the Perineum." Trans. of Am. Gyn. So. 1885. Vol. X, p. 147.
8. Goodell—"Lessons in Gynecology."
9. Ramsbotham—"System of Obstetrics."
10. Fasbender—Zeitsch. of Geb. und Gynec. 1877-8 Vol. II. p. 43.

## TREATMENT OF SEPTIC CONDITIONS OF THE UTERUS.\*

BY M. S. MARCY, M. D., PEORIA.

While the uterus is an organ capable of withstanding much abuse, it is also one of the most fertile fields for the introduction of poisoned material into the circulation of any organ of the female body. The denuded surface of the interior of the organ, after confinement, miscarriage, or abortion, with its increased vascularity and distended absorbents ready to carry any septic material into the circulation renders it a very dangerous organ, under certain conditions, to which we desire to call attention.

Under natural conditions when the woman has passed through her confinement nature, if not interfered with, usually restores the organ to its normal condition, barring lacerations.

In unnatural labors, however, requiring assistance quite frequently some septic material may remain in the uterus and cause trouble, or the os uteri may be badly lacerated and absorption of septic material take place at this point.

As our limited time will not permit us to enter into a discussion of all of the phases of this subject, we will for the present dismiss the part relating to septic conditions after confinement, with the remark that the same treatment of which we shall speak will apply equally as well after confinement, as after a miscarriage, or an abortion.

In the few moments allotted to us we shall speak only of the treatment of actual abortion.

As with all other subjects, physicians differ in their opinions as to the management of this class of cases.

These various opinions published must be somewhat confounding to the young practitioner, who has not had experience of his own to compare with the writers on this subject, and judging from the number of deaths occurring annually from abortion it might indicate that some of the older practitioners were either at a loss to know just what the proper treatment should be in these cases, or that they were beyond successful treatment when first seen.

When called to a case of actual abortion, the treatment depends to a great extent as to how far pregnancy had advanced, the condition of the patient, and the sanitary surroundings.

Should there be no immediate danger from hemorrhage and the patient is rational, the physician should endeavor to ascertain the cause that produced the trouble, especially is this necessary under suspicious circumstances, not only that he may treat the case more intelligently, but for his own protection.

Should the conditions lead him to think that there is liable to be the least bit of trouble for himself, he is very unwise who does not insist on calling council. Many innocent physicians have had cause to regret for the remainder of their lives the neglecting of calling council in these cases.

During the first two months if no hemorrhage of a serious nature occurs, nor rise in temperature is noticed, very little treatment is needed except rest in bed.

During the third month the ovum may be expelled entire without rupture of the membranes, in *such* cases very little treatment will be required.

When the sack ruptures however, and the liquor amnii escapes, the sudden reduction of pressure exerted by the ovum upon the intra uterine surface is very likely to produce free hemorrhage from the utero placental vessels.

It is during this excessive stage of flowing that the physician is most liable to be called and now he must be ready to act quickly and advisedly.

\*Read at the 52d Annual Meeting, Quincy, May 21, 1902.

A look at the patient's face, and a touch of the radial artery should tell him of his patient's condition.

If the flow of blood is alarming, the foot of the bed should be elevated as high as possible, tampons of cotton dipped in boiled vinegar, sterile water, weak solution of potassium permanganate, or any aseptic solution that may be nearest at hand should be pushed into the uterus if possible, if not the vagina should be thoroughly packed, hot saline solution should be injected into the bowel, or vein if prepared for the operation. Strychnia, digitalin, and nitro glycerine may be administered hypodermically when needed to sustain the heart.

All this should be done in order and as rapidly as possible without excitement.

Notwithstanding severe hemorrhage produces a condition which is sometimes alarming, comparatively few deaths occur during abortion from this cause.

Infection is the one thing to be dreaded.

Denslow Lewis says Infection is a danger a thousand times more serious than hemorrhage, and by far the greater number of deaths are due to infection.

This being a generally admitted fact we may with profit for a few moments consider carefully this all important condition, the causes that produce it, and how they may be prevented.

Should we find the patient has produced abortion on herself, or permitted it to be done by another, with some dirty instrument, we may find the patient suffering not only from infection, but peritonitis at our first visit, and this condition by the way is one where we should call council.

Again we may find the patient with a high temperature and delirium, produced by absorption of retained secundines or placenta in a state of septic decomposition.

When these conditions exist before we are called we do not feel in the same degree the responsibility, felt when infection takes place after the patient comes under our care.

Our efforts to save the life of the patient however, should be none the less active.

When called to see a case where the foetus is presenting, our duty is plain, namely to

remove it as soon as possible which usually is an easy matter.

This being done the greatest problem in these cases presents itself, as to what is the correct thing to do next.

And here is where the diversity of opinions begin, a few of which we wish to quote.

P. Muller says—It is best to leave as long as possible the expulsion of the ovum to the natural forces, which in many cases of abortion is better able to do it than our hands and instruments, when danger exists interference is permissible.

E. J. Hill, writing on this subject states—That a temperature of 101 is always a distinct indication for immediate cleansing out of the uterus, followed by large hot antiseptic intra uterine injections and the uterus should be drained by gauze.

R. L. Payne, in the North Carolina Medical Journal says—So long as abortion is progressing safely all interference, and especially curettage is to be depreciated, but as soon as septic symptoms arise then the uterus must at once be emptied of its contents and the curette is the best instrument.

Ch. Patrué says—The curette is not sufficiently employed in cases of abortion. Used in 134 cases the haemostatic effect was immediate, the flow of blood ceasing as soon as the uterine cavity was relieved of its contents. The hemorrhage should serve as a guide to the operator, who should continue curetting until all flowing has stopped, or until the last of the debris has been eliminated.

Tarnier says—When intervention is necessary I simply use my finger instead of the curette, the curette is a blind instrument, which I only use when there is hemorrhage or infection.

Goldburg says—Many accidents have been attributed to the curette.

Recamer, reported three cases of perforation of the uterus by the curette.

Dumarquay, reported two cases; Chamberlain had a case of hysterical tetanus; Peasley a death from collapse; Thomas a narrow escape from the same cause; Parker a case of peritonitis.



Goldburg states that he has used the curette in a large number of cases without accident.

Maygrier states in 99 cases requiring operative interference 55 were treated by digital exploration and removal of fragments, and 44 cases were treated by curetting, six deaths occurred. In two cases a perforation was found at the fundus uteri with peritonitis. One of these curetteages had been carefully performed, the other case the uterus had been merely packed with gauze.

One case was due to suppurative salpingitis.

The remaining three were due to infection before coming to the hospital. We might add the experience of many more able writers on obstetrics, but the above should be sufficient to demonstrate one point which we wish to make prominent; namely, that the curette even in the hands of skilled men is somewhat dangerous, and the use of it has produced death in many instances.

Because the curette has been the means or cause of many deaths, does not warrant its condemnation under all circumstances, but it should teach the profession to be more cautious in its use and not to use it until all other *harmless* methods have failed.

Abortions are of common occurrence in every physicians practice, and it is impossible especially for the country practitioner to secure the services of a professor of obstetrics to assist him in using the curette.

Tarnier well states, that the curette is a blind instrument, and how is the amateur to know when to cease scraping the inside of this sensitive bleeding organ? By following Ch. Patric's advice and continue to curette until all flowing has ceased, or until the last of the debris has been removed?

With all due respect to the opinion of Patric, we say *no*.

Other means should be used which are superior as a haemostatic and which will do no damage to the uterus.

While the operator is endeavoring to scrape away the debris, he may also be scraping away the softened mucus membrane exposing the bleeding vessels and absorbents, and by so doing favoring the absorption of septic material and thereby assisting in producing

septicemia the very condition he so much desires to prevent.

What then is the proper procedure after the foetus has been expelled. The operator should prepare himself and the patient as he would for any other surgical operation. Remove with the finger all debris that is detached or that may be easily detached.

If it is a placenta it must not be torn but should be let alone if not detached or can not be as a whole. We must remember that it is doing no harm as long as the temperature is normal, it may remain several days without the least harm.

The patient should be examined at least twice a day as to temperature and to learn if the placenta is yet detached. At the slightest rise in temperature, or even before if we can not see the patient often a clean fountain syringe should be ready with a sterilized glass uterine tube attached, pour into the bag a half pint of hydrogen dioxide, diluted with one-third sterile warm water, allow it to flow while introducing the tube into the uterus to prevent air entering the uterus.

The os uteri must be sufficiently dilated to allow the free escape of the fluid. Have ready also a pitcher of hot sterilized water in which has been dissolved a few tablets of potassium permanganate with which to continue the douche, this procedure should be repeated as often as necessary.

Never allowing any one but yourself or a trained nurse to do the work.

What have we accomplished by this procedure? First, we have checked the hemorrhage with one of the most powerful and harmless styptics at our command. Secondly, we have destroyed all poisonous material and rendered aseptic all debris with which the solution has come in contact. This is easily proven by examining pieces of placenta or any debris as it is removed from the uterus, large pieces that were before the injection very offensive and rapidly decomposing are found to be bleached and odorless.

Should there be a necessity for using the curette, this injection should always be used first, for the purpose of rendering the debris harmless and thus to prevent the instrument

from infecting the patient. After the contents of the uterus has been rendered aseptic with this solution the temperature usually falls to normal within a few hours.

The physician can then rest easy until the placenta becomes entirely detached and is easily removed with the finger. The writer has followed this method for ten years past without the loss of a patient from septicemia or hemorrhage, notwithstanding a number of them have had a temperature of a 103 to 106 with delirium when first seen.

It is somewhat surprising to hear the objections offered to this treatment and the arguments against using hydrogen dioxide within the uterus, but I have noticed the strongest objectors are those who have never given the remedy a trial.

Many physicians say the remedy is unsafe and they fear to use it because when it comes in contact with debris the oxygen is liberated thus generating a white foam which may cause gas to enter the fallopian tubes and thus cause trouble.

From my experience during the past ten years with this remedy my convictions are that this fear is unfounded and conclusions wrong, providing the precaution has been taken of having the os uteri well dilated to allow the fluid to escape.

Others state that hyd, bi, chloride, lysol, carbolic acid, saline solutions, potassium per manganate, and various other remedies will accomplish the same results without the danger.

If there is a physician present who from his own experience or from statistics can prove that there is another remedy when injected into the uterus containing a decomposing placenta that will at once render this septic mass, bleached, odorless, and harmless without doing violence to the uterus itself, I shall be under lasting obligations to him for his report.

This hardened odorless mass will remain so for several days until nature has had ample time to expel it from the uterus.

#### Discussion.

C. B. Reed, of Chicago: That this subject is of considerable importance is easily seen when we stop to consider that in Germany alone there occur annually 44,500 cases of puerperal infection, from 12,000 to 15,000 of them

very badly infected. This does not include cases following abortion, but simply those following normal labor. The treatment of these cases is of considerable importance. I had the honor of reading a paper on this subject before this Society last year, and my views on the subject have been pretty well gone into, so that I will not weary you with a repetition at this time. However, I will say, in regard to the paper, that I do not believe that the intrauterine douche, even when used with antiseptics, is of any value whatever. I have come to that conclusion after considerable experience. I do not believe that washing out the uterine cavity with antiseptics is of any value at all, from an antiseptic standpoint. I am convinced that it is a positive danger to the woman, and, furthermore, that what washing out is done to remove debris from the uterine canal could be more easily done by using a saline solution or some alkaline solution. The danger of death following the use of the intrauterine douche is not remote, and many cases have been reported.

In regard to the use of hydrogen peroxide, as mentioned by the essayist, I would look upon its use with considerable suspicion. Those of us who had the opportunity of reading Dr. Hektoen's laboratory report on cases of air embolism following an open uterus can readily appreciate the possibility of air embolism occurring in these cases from the formation of gas by the hydrogen dioxide. This gas can easily be forced into the circulation, and cause embolism. Several French writers have recently reported two cases where this occurred.

In regard to the use of the curette, I would say now, as I said last year, that I believe it is a dangerous instrument to use in the uterus, except when used by the skilled hand. I believe digital curettement should always be employed, and we should always call attention to the dangers of the curette. Last year, in my paper, I called attention to the danger of perforation of the uterine wall by the curette, and remember well that I was severely criticised by Dr. Brown, of Sycamore, for the stand I was taking. Last night the doctor told me that he had recently performed a post-mortem on a woman whose uterus had been perforated by the curette, and he apologized for his remarks of the year before. The danger of perforation cannot be over-estimated.

So far as leaving the placenta in the uterus is concerned, I cannot agree with Dr. Marcy. I believe it is absolutely wrong to leave any membranes or portions of decidua or placenta in the uterus longer than twenty-four hours. It is certain that the uterus must be absolutely clean before the patient can be left, so that it may drain itself. The source of infection usually is debris which is left behind in the uterine cavity. If this cavity is left clean, the danger of infection is not only remote, but impossible. If the infection does not arise from the debris, the source is usually the thrombi in the uterine wall, and is not removable by douching, curettage or any other measure short of surgical interference. The cul de sac should be opened and thorough drainage instituted by a through and through tube from

above Poupart's ligament down through the cul de sac into the vagina, or following the method recommended by Pryor or by performing a complete hysterectomy. When the infection has become general, local measures are of absolutely no avail; in fact, it is wasting time. I wish to cite a case that occurred in the service in the Lying-In Hospital. I assisted at the post-mortem of the woman, which was held eighteen days after a perfectly normal labor. Two days after the labor there was a sudden rise of temperature, and all the evidences of a general infection. All local measures failed to produce any amelioration of the symptoms. At the post-mortem we found a large infected thrombus in the cul de sac. I am convinced that if a careful examination under anesthesia had been made, this mass would certainly have been discovered, and the woman's life saved, beyond question.

**Dr. Marcy** (closing the discussion): My experience certainly differs very much from Dr. Reed's. I am very much surprised to hear him say that he has had no experience with hydrogen peroxide himself, but refers to the reports of some French writers who had two deaths following its use. I always like to hear a man speak of things he has used himself, and then express his opinion from the conclusions he arrives at. When the os is perfectly dilated, I am convinced that no harm can follow the use of hydrogen peroxide.

Dr. Reed says he would not leave the placenta in the uterus more than twenty-four hours after the conclusion of the labor. That is where physicians make a serious mistake. Nature intended this placenta to stay for nine months, and when the baby is prematurely born the doctor tears it away long before its time. I am convinced that the after-birth should not be torn away. Render it aseptic with peroxide of hydrogen, and leave it behind. Nature will tear it off in due time without tearing it away forcibly and without any danger to the woman. This will also obviate the occurrence of air embolism to which the doctor has referred, because when the uterus contracts as it should, there are no sinuses left open through which the air can enter. Tearing away the placenta certainly favors air embolism.

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## FRACTURE OF THE FEMUR AND ITS TREATMENT.\*

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Before considering the treatment of fracture of the femur, I will review briefly the anatomy.

*Anatomy.* The femur is the largest and

the longest bone in the body. Normally, it is inclined inward and slightly backward, and articulates with the hip bone above and the tibia below; the upper extremity, the head, neck, and the two trochanters. The head forms within half a sphere, and is covered with cartilage, except at that place where the ligamentum teres is attached. The neck, which is an outgrowth from the shaft, extends inward, upward, and a little forward from the shaft to the head. Its length is greater behind than below, and it is concave behind. The axis forms at an angle of 125° with that of the shaft; at birth at about 160°. During growth it decreases from 140° to 110°. The great trochanter is quadrilateral, continuous with the outer surface of the shaft. The gluteus medius is attached to it; the small trochanter projects as a pyramidal eminence from the dorsal internal aspect where the lower end of the neck joins the shaft. The shaft is nearly cylindrical and expands as it approaches the lower extremity. The lower extremity presents two condyles, most prominent behind, where they are separated by the intercondyloid notch, while in front they are united by the trochlear surface over the patella. Ossification occurs in the shaft from one center, the lower epiphysis, and for the head and great and small trochanters, one center. These join the shaft of the small trochanter at about the age of seventeen years, the great trochanter at eighteen years, the head at nineteen years, and the condyles at twenty years.

A great number of normal lower limbs are of unequal length. The left limb is often longer than the right. The average inequality of normal lower limbs is probably about one-quarter of an inch. The average amount of shortening, after a fracture of the femur, is about three-quarters of an inch. After a fracture, in some cases the limbs are of equal length. One limb can never be a certain standard of length for the opposite limb, and we must remember that a variation of the lower extremity in length is mostly in all cases in the femur, and not in the tibia.

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\*Read at the 52d Annual Meeting, Quincy, May 21, 1902.



*Etiology.* The local causes of fracture of the femur are: (1) direct violence; (2) indirect violence, and (3) muscular action.

Spontaneous fractures occur in those cases where the bone has been weakened or rendered brittle by disease, as by mollities ossium. The most frequent cause is a fall upon the outer side of the hip, the neck of the femur being weakened by the senile osteoporosis. The cause of fracture of the neck is senile rarefaction, beginning at about the age of fifty, and it is more common in females than males. Stepping out of a carriage is a very frequent cause. The strain exerted on the ligaments in extreme position of the limb may be a more frequent cause of fracture than is generally supposed, and the fall is sometimes the consequence rather than the cause.

Golebiewski (*Diseases Caused by Accident*, page 371) says: "Old persons are most subject to fracture of the neck of the femur, due to porosity and lessened elasticity of old age. But even in a strong, young man, showing no signs of syphilis, tuberculosis or rickets, a trivial cause may, under certain conditions, suffice to produce a fracture." This author then mentions six cases of fracture in extremely vigorous, young hod-carriers, in all of whom the fracture was caused by a misstep or outward movement when carrying a heavy load on the shoulder. I had a similar case about a year ago. The fracture in this case was due to tension of the ilio-femoral ligament when the hip joint was over-extended. We know that fracture of the femur is more common in old persons, and the causes may be a misstep, a stumble, a fall upon the knee or hip, or it may be due to a thinning of the cortical shell and enlargement of the meshes of the spongy tissue.

Fracture of the head of the femur is a very rare accident. Stimson in his book (page 304) speaks of three cases; one, Riedl's case, which was run over by a wagon; the head was split, and the acetabulum was crushed. Then he refers to the case of Brown, in which the line of fracture ran from the insertion of the ligamentum teres to the

attachment of the capsule. He then speaks of his own case, in which the anterior portion of the head was crushed. The neck of the femur is constructed to resist lateral as well as vertical pressure, and the arrangement of the cancellous tissue accords with this firmness and elasticity, which are mingled in the structure of both the neck and head of the bone.

Golebiewski speaks of the great carrying power of the neck of the femur, which is explained by the internal structure of the neck and head of the bone, in which the mathematical laws upon which its strength is based are clearly displayed. When the limits of its elasticity are exceeded, fracture of the neck of the femur is an inevitable result.

In fracture of the lower third of the femur the causes are direct violence or indirect force, as a fall upon the foot or knee, or a combination of torsion and traction. Fracture of this portion of the bone assumes considerable gravity on account of the proximity of the knee joint, the possibility of the popliteal artery being compressed or lacerated, and the tendency to excessive blood extravasation from the torn vessel of the vascular bone and the investing periosteum.

*Pathology and Repair.* As to the healing of a fracture, when the bone is broken there is more or less hemorrhage. The surrounding tissues are torn and infiltrated with blood. There is inflammatory exudation to a moderate degree, and cellular migration takes place. If there is no infection the inflammation subsides in the course of a few days and is followed by regenerative proliferation.

The formative tissue produced by the periosteum is known as external callus; that which extends in between the fragments is known as intermediary callus, while the tissue from the medullary portion is known as the internal or myelogenic callus.

As to the process of repair, on the second day after a fracture the parts in its immediate neighborhood are infiltrated with leucocytes, and active cell proliferation takes place with fusiform, angular or stellate cells,

and so the tissue assumes a bony substance. The newly-formed bone forming a spindle-shaped swelling extends for some distance above and below the injury. The new bone formed from the medulla and periosteum is absorbed, while one fragment with the other constitutes cortical bone. As to the cicatrix of bone, the bone tissue has the power of reproducing itself after an injury. It is only in exceptional cases that this does not occur. When a long bone is broken there is a great deal of injury, as a rule, to the surrounding parts. The Haversian canals are ruptured, and there is considerable oozing of blood between the bony fragments and into the surrounding tissue. The soft parts are more or less lacerated, and in almost all cases we have rupture of the periosteum as the result of this injury. Traumatic inflammation occurs at the seat of fracture, and in a few days the tissues in the neighborhood are infiltrated with blood clots, and are matted together by the condition which takes place. The callus is not well defined in outline, and involves bone, periosteum and connective tissue, and even some of the surrounding muscular tissue. In the second or third week of the process of repair the blood clot is absorbed, forming a dense tissue in and beneath the periosteum which develops into cartilage. The fatty tissue of the canal disappears near the fragments and is replaced by granulation tissue.

Ununited fractures are the result of inability on the part of the bone-producing structures to form new bone. The inflammatory tissue is absorbed, but no new bone is thrown out. The ends of the two fragments lose their sharp edges by the absorption of the bone. Pseudarthrosis is brought about by the ununited ends of the bone, which are covered by cartilage and ligamentous bands which hold the ends together by a capsule which may contain a small amount of clear serum. Unskillful treatment is not so frequent a cause of non-union as has been heretofore thought.

The capsule is usually attached to the femur along the spiral line above to the neck, a little short of its junction with the tro-

chanter behind to the neck, it being about half an inch from the inter-trochanteric line and below to the upper part of the lesser trochanter.

The vitality of the head of the femur in cases of fracture is preserved by a branch of the internal circumflex artery, which runs along the upper portion of the neck and enters the head, and the upper portion of the periosteum is not torn in most cases of fracture of the narrow part of the neck. In fracture through the great trochanter and neck the line of fracture begins at or near the lower part of the junction of the head with the shaft and passes through the great trochanter. This injury is not a common one, and if it does exist, it is generally due to forcible extension of the limb in which movement of the neck and trochanters is arrested by the Y ligament, and fracture takes place below or through its lower attachment.

Fracture of the great trochanter, independent of fracture of the neck, very seldom occurs. The cause appears to be a blow upon the outer portion of the trochanter, and even muscular action might cause this injury. The symptoms of this fracture are local pain on pressure and mobility of the fragment. The patient is able to walk. The treatment consists of immobilization and pressure by a bandage applied about the hips for fracture of the great trochanter.

Fracture in the upper third of the femur below the lesser trochanter is always attended with considerable deformity and shortening. The upper fragment is tilted forward by the ilio-psoas, pectineus, adductor brevis, and gluteus minimus muscles, and by the pressure of the lower fragment which is drawn upward by the muscular action and general retraction of the soft structure.

In fractures of the shaft of the femur, the fracture is generally oblique, and often extremely so. Transverse fractures of the shaft are rare in adults, but more common in children. The displacement is angular, the angle usually being directed forward and outward, and is due to the contraction of the gluteal and psoas muscles upon the

upper fragment, and of the adductors and flexors of the leg upon the lower one, but a fragment may be displaced backward and inward. Extreme obliquity of a fracture, which is not an uncommon thing, may lead occasionally to a troublesome complication. It may change a simple fracture into a compound one by penetration of the muscles and sometimes skin by the sharp end of the upper fragment.

Fracture of the shaft about the middle is quite common. When it is due to direct violence, the breech in the bone is usually transverse, while, when it is due to indirect violence, it is usually oblique. It will be generally found that the lower fragment is drawn upward behind the upper fragment in consequence of the united contraction of the ham-string muscles, the tensor fascia femoris, the rectus, the gracilis, the sartorius, and the adductors. The adductors draw to the inner side, increasing the natural outward inclination of the foot and leg. In young children eversion of the foot and leg is not as marked as it is in adults, on account of the shortness of the neck of the femur, and on account of the external rotators which are not exercised to maintain the equilibrium in the erect position. But let us remember, that natural eversion of the foot in adults persists during sleep and under anesthesia, on account of suspension of muscular contraction.

In a fracture of the lower third of the femur there may be a communication with or without impaction of fragments. In childhood and youth the lower epiphysis alone may be torn away. The displacement depends chiefly upon the direction of the fracturing force and the lines of obliquity presented by the fragments. When a fracture occurs above the insertion of the gastrocnemius muscle, the lower fragment may, in exceptional instances, become so strongly flexed by the contraction of this muscle that the fractured surface projects backward into the popliteal space, and great difficulty may be encountered in securing proper adjustment of the fragments, that is, to relax the muscles so as to flex the leg from the thigh, and sometimes the muscular contraction is

so strong that some authors recommend even section of the tendo-Achilles to put the action of the muscle at rest. I have never found it necessary to do this in any of my cases, and after anesthetizing the patient I find there is relaxation of the muscles.

In cases of intercondyloid fracture the condyles are separated from the shaft and from each other. The line of fracture may be T or Y shaped. The main line of the fracture across the shaft may be very oblique, as in a fracture of the lower third, but it is usually more nearly transverse in its general direction. With splintering it makes the surface irregular, and this lies close to the base of the condyle, and the separation is due to the upper fragment being impacted into the lower one, and the separation of the condyles is merely a fissure.

*Diagnosis.* As a rule, in fracture of the neck, the patient is not able to use the limb, even to move it in bed. Pain is always present and is excited when the patient moves the limb. When the patient lies upon his back the affected limb appears shorter than the other, everted and slightly flexed, as well as abducted, and conveys the impression of helplessness. The upper portion of the thigh is swollen in front and at the outer side. Ecchymosis appears in about two days or so. The greater the shortening, the more marked is the swelling. Eversion of the foot is very marked. The foot may rest entirely upon its outer border as the patient lies upon the bed. In very exceptional cases we may see inversion. Crepitus, which is occasionally observed during the manipulation of the limb, while making traction or rotation, is not a constant sign, either because of the impaction or of the splintering which leaves the pieces too closely connected to produce crepitus. Shortening is produced by alteration of the angle between the shaft and the neck or by overriding of the fragments. This shortening may vary all the way from the fraction of an inch to two or even three inches. In measuring the limbs, both sides must be at the same angle; that is to say, when the injured limb cannot be brought parallel to the



median line of the body, the other must be abducted to the same degree. In taking measurements for the purpose of ascertaining the degree of shortening, it is essential that the patient's body should rest upon a firm, unyielding surface, with the pelvis so placed that a line drawn between the anterior superior spinous process of the two iliac bones will bisect at a right angle with the straight line of the body. This being assured, either measurement may be made from the umbilicus to the inner malleolus of one leg to that of the other, or the tape-line may be held by the patient with the foot, while his head is immovably held in the straight line of the body, and the length of the inner malleolus from one leg with the length of the inner malleolus of the other.

*The Nelaton Test.* The patient is placed in a supine position; the limb is extended in the axis of the body; a piece of tape is stretched from the anterior superior spinous process to the most prominent part of the tuber ischii; if the trochanter is in its normal position, the middle of the tape ought to just skirt the upper border of the trochanter.

Shortening is due to the elastic contraction of the soft parts, and to the degree of overlapping of the fragments of the broken bone.

In order to make a positive diagnosis, it is not necessary to resort to too much manipulation, especially where there is doubt as to the existence of a fracture, and whether the thigh is simply bruised or fractured the most accurate way is to use the X-Ray. We can use the X-Ray with the fluorescent screen or fluoroscope, and the limb must be examined anteroposteriorly and from a lateral point of view, as it may happen that the photograph will not show a fracture even when it exists, that is, when only one view of the extremity is taken. It is necessary, therefore, to take both views. I recall one case of fracture which did not show with the fluoroscope in taking one view of it, while with another view it could be easily seen. Williams reports similar cases where this error has been made. This error might be made quite frequently by an inexperienced

person in the case of children, because the epiphyseal line of a child may be mistaken for a fracture. To avoid making this error, one should compare the sound limb with the affected one.

*Prognosis.* After a fracture of the femur some permanent impairment of function of the limb is to be expected in all cases. This may vary from a slight limp to total helplessness of the limb. This impairment of function is not uncommon in aged persons from the effects of shock and the local inflammatory re-action which frequently follows after some weeks or months from renal and pulmonary complication, induced or aggravated by confinement to bed.

Non-union is due to the absorption of the neck of the femur, and a serious effect upon the general condition of the patient is produced by being confined to bed.

As to the prognosis in cases of fracture of the neck of the femur, the primary inflammatory re-action is sharp; high fever sets in; the patient becomes delirious, and he may die within a few days, or pneumonia may develop soon after the accident and prove fatal. In some cases intercurrent pneumonia sets in. The patient becomes very cachectic, and probably fat embolism of the lungs or other conditions produce an unfavorable prognosis. Stimson (*Fractures and Diseases*, page 325) says, that death is the apparent result of marasmus due to prolonged confinement to bed and constant pain. Union may take place almost invariably with some deformity, and with some limitation of motion at the hip. The limb is short and everted, and abduction is diminished by a change in the angle of the neck with the shaft. Failure of bony or fibrous union does not necessarily cause complete disability. A patient may be able to use the limb more or less, and sometimes for several years, but in most of these cases the neck disappears and the surfaces of the head and shaft become smooth.

Wyeth, in his *Surgery*, page 383, states that in fracture of the neck of the femur union is scarcely to be expected. Wharton and Curtis (*Surgery*, page 480) state that the prognosis is generally grave, since bony

union practically never occurs, and the functional result is always imperfect.

In cases of impacted intracapsular fracture of the neck of the femur, bony union does not take place; although to all appearances the fragments seem firmly fixed, they are quite likely to become separated from time to time. In the so-called extracapsular fracture the neck becomes united to the shaft at a less obtuse angle than normally, therefore depressing the pelvis on the affected side and causing apparent shortening of the limb.

Senn (Practical Surgery, page 461) says: "In no other fracture are the indications for successful treatment so difficult to meet as in fracture of the neck of the femur. Every unprejudiced surgeon is forced to admit that the usual bad results in these cases are owing more to the inefficient treatment employed than to the anatomico-pathological condition of the broken bone."

The causes of non-union are not to be found in the broken bone, but in the difficulties encountered in the treatment. Intracapsular fractures of the neck of the femur either fail to unite or unite by fibrous union. Bony union cannot be expected, owing to the slight vascularity of the upper fragment and the patient's age. Permanent shortening and lameness are the natural results. Hypostatic congestion, pneumonia, and bed-sores are to be expected if a patient is confined to bed. The patient should be warned that a certain amount of permanent shortening, usually about half an inch, will result.

Speaking of fracture of the shaft of the femur, the International Surgery, Vol. 1, page 571, states that the injury is always a serious accident, requiring unusual methods of treatment, confinement to bed for weeks, entailing considerable disability and lameness for months, and in some cases such shortening as to cause a permanent limping gait. It states further that when intelligently treated, the patient at the end of eight weeks may be able to leave the bed and go about on crutches.

We may expect in every case bony or close fibrous union. There may be enough of

the periosteum preserved to maintain the vitality of the head, and the primary displacement does not usually separate the fractured surface. If the case is carefully handled and no attempts are made to use the limb, if the muscles have not been active before the traction has been applied, the conditions for reunion of the bone are quite favorable.

*Treatment for Fracture of the Neck of the Femur.* The shortening can be overcome by gentle traction upon the limb, combined with enough rotation inward to correct such eversion as may exist. The patient should assume the recumbent position, with continuous extension, in a proper bed. This bed should be narrow, about thirty-six inches in width, with hair mattress four inches thick, placed on an even, unyielding surface, with holes in the mattress, and particularly an apparatus for raising the patient.

As to the time for bony union to take place in a case of fracture of the femur or of its neck, Gurlt states that it varies from fifty to two hundred and seven days, the average duration being eighty-four days. Dupuytren estimates it at from one hundred to a hundred and twenty-two days, and states that it was customary at the Hotel Dieu to keep these patients in bed from eighty to one hundred days. Senn states, that in order to prevent secondary displacement, the retentive apparatus should not be removed for at least from eighty to one hundred days.

S. C. Plummer (Annals of Surgery, May, 1902, page 662), in speaking of the treatment of separation of the lower epiphysis before the Chicago Surgical Society, presented a boy, fourteen years of age, whom he treated by a double inclined plane, the knee being flexed at a right angle, and the boy allowed to remain there from July 5th until August 8th. Good solid union had occurred, with fairly good motion.

In discussing this case, William E. Schroeder stated that when patients are put to bed they are very apt to have epiphyseal separation from a slight trauma, and recalled the case of a boy with tuberculosis of the hip joint, put up in a cast. The

boy remained in bed for some time, then Dr. Schroeder removed the cast and found separation of the epiphysis. The boy was put in a cast again, but it required three or four months more before union had taken place.

As to nailing the head of the femur, Bryant (Volume II, page 1276) states that there are two conditions for the relief of which this procedure has been employed. First, for recent fractures in aged patients, the deformity renders it inexpedient to subject the sufferers to prolonged mechanical treatment with the attendant risk of non-union and exhaustion. Second, in cases of ununited fracture of the neck of the femur. Koenig makes a small incision over the outer side of the trochanter major; drills a hole in the direction of the head of the bone, then drives a long steel nail through the canal in the trochanter into the head of the bone and leaves it there. He immobilizes the limb for six weeks. Cheney exposes the fragments by means of a longitudinal incision made over the anterior aspect of the joint. He makes extension and internal rotation of the limb. He makes a longitudinal incision over the trochanter major and two canals drilled through the fragments at a distance of half an inch apart. Ivory is then driven into the holes made by the drill, and then the limb is immobilized.

*Buck's Extension.* For this purpose a strip of stout adhesive plaster, four inches wide, and long enough to reach above the knee, and usually around the sole of the foot and back to the same height above the knee, is used. A piece of wood, about three inches wide, and perforated at its center, is placed at the middle of the strip, the edges of which are turned down over it and over each other; a stout cord is passed through the hole in the piece of wood and its end is tied in a knot. A roller bandage is applied to the foot and the lower third of the leg; adhesive plaster is applied to the side of the leg and tied above it, and secured by continuing the bandage upward. The cord is then carried over the pulley at the foot of the bed and attached to a weight of from

ten to twenty pounds. The foot of the bed must be raised to obtain counter-extension of the weight of the body.

Hodgen's splint acts on the same principle as Buck's extension, and has the additional advantage of affording slight flexion of the knee and is of greater facility in moving the patient in bed. It is attached to the leg by adhesive plaster in the same manner as Buck's extension, and the traction is regulated according to the deviation of the supporting cords from the vertical direction. Hodgen's splint is a modification of Smith's anterior splint. The limb is secured to the foot of a wire frame by means of a stirrup and secured to the frame by a cord. The strips are attached to one side of the frame, and then brought around beneath the limb, one by one, and pinned to the opposite side.

The metal splint for fractures of the shaft of the femur is employed to press down the upper fragment into place, and is used in addition to the weight and extension.

Vertical extension in fracture of the femur in children, with Bryant's double splint, consists of two long parallel outside splints with brackets attached, opposite the trochanter, and connected above and below by adjustable metal bars which allow for separation or for approximation of the splints according to the size of the patient. The sound limb is fastened firmly to the splint by a strip or bandage applied to the injured limb. Extension is applied by means of a stirrup, the cord passing around the ball of the foot to the splint end, being fastened to an elastic door spring by which the requisite amount of extension is made.

The Thomas hip splint has rings to surround the leg just below the knee and a ring to enclose the thigh just above it. A stout metal band encircles the chest, and the splint is kept in place partially by a bandage and partially by braces, also having elevation or a patten to the boot on the sound side, fastened by screw plates.

Senn's method of treating fracture of the femur: Patient is dressed in a well-fitting night drawers and a thin pair of stockings



over the joint, and where greater strength is required wood shavings or strips of tin are placed between the layers of plaster. The bony prominence is protected with cotton before the plaster-of-Paris is applied. The fractured limb is first encased in a dressing as far as the middle of the thigh. After the patient is lifted by two strong persons, the physician supporting the limb to guard against additional injury, the patient is placed in an erect position, standing with his sound leg on a stool two feet high. In this position he is supported by a person on each side until the dressing has been applied and the plaster has set. A third person takes care of the fractured limb, which is gently supported and immovably held until permanent fixation is secured by the dressing. Professor Nicholas Senn immobilizes the fractured limb, the entire pelvis, and the opposite limb as far as the knee, and extending the dressing as far as the cartilage of the eighth rib. The splints rest directly upon the trochanter major, and the pressure that is made by a set screw is directed in the axis of the femoral neck. The set screw is projected and a key is used in regulating pressure.

The Hamilton splint, which is practically a model of Lister's splint, is united below by a cross-piece for fixation of the pelvis.

Charlie Stonhan recommends, before the Hamilton splint is applied, that a short splint be put on. This splint usually reaches from the groin to the knee on the anterior and posterior aspects, the limb being fixed by two webbing straps with buckles.

The treatment of fracture of the femur by the ambulatory method is a combination of the steel supporting bar with adhesive traction strips and muscle and fixation bandage along with a plaster-of-Paris bandage. After a diagnosis has been made of fracture of the femur, it makes no difference where the fracture is, if it is a fracture of the neck, or of the shaft, of the lower extremity, or an intercondyle fracture of the femur. I apply this dressing in all of these fractures and use this dressing for both young and old.

The method is as follows: First, the patient is anesthetized; the limb is then

shaved if there are hairs on it; soap and water are used, followed by bichloride solution, and subsequently alcohol. If I am called to see a case immediately after an accident, if there is swelling I put on a tight bandage, beginning it from the toes and going clear up above the fracture, and keeping this tight bandage on for fifteen minutes; in other words, drive the swelling away. A recent swelling will not do any harm to the general condition of the patient. In cases in which I am called in after two days, where an inflammatory process or a proliferation of the cells has taken place, I simply wait until the swelling subsides, and then apply the same dressing.

I take adhesive plaster, one and one-third inches in width, starting from the level of the lower fragment and going clear down to the heel under the malleolus on both sides of the leg, making the adhesive strips hang three inches below the heel. Next comes a thin layer of sterile gauze, covering the whole limb and hip region and around the abdomen. Over this is applied a linen bandage, starting from the foot, and extending up far enough to fix the hip joint. After this comes the plaster-of-Paris bandage. Before I use it I always bake the plaster-of-Paris bandages in an oven to drive the moisture which is absorbed from the atmosphere. I do not use salt for the plaster-of-Paris, as it makes the plaster-of-Paris brittle. Then, I apply a plaster-of-Paris bandage, starting from the foot and going clear up and down, making for an adult four or five layers of plaster-of-Paris bandage, and for a child three layers. The steel bar is the next thing which is applied, which is about three-sixteenths of an inch in thickness, and one and one-half inches in width, made with a hook, which hook comes under the heel. Over this bar I place four or five layers of plaster-of-Paris bandage in the case of an adult, and about three layers in children. While this is applied, the fractured limb should be well extended and kept in place. I wait until the plaster-of-Paris hardens, and when it is hardened I put lengthwise of the heel a piece of roller bandage and tie the adhesive plaster over this, and by means of a cord I

tie it to the hook of the steel bar. The steel bar must go over the region of the hip so as to assist in immobilizing the hip joint, and must be moulded according to the shape of the limb, extending about two inches below the heel. I leave the dressing on in the case of an adult for five weeks, and in the case of a child for about three weeks.

#### REPORT OF CASES.

Case I. Mary K., eleven months old at the time of the accident. American-Polish descent. Family history: Father is 32 years of age; mother 19 years old, healthy; one sister died at the age of six months. No hereditary disease. On Saturday, May 7th, 1898, I was called to see this little patient and found her in the cradle, crying and restless. The history the mother gave me was this: She was preparing supper for her husband and left the child in the cradle; the little one had had stomach trouble for a few days previously, with colicky pains, as she describes: "Mary was asleep and awaked and cried out and started to holler." The mother did not touch her, but sent for the nearest doctor, who made a diagnosis of fracture of the thigh bone. Just as the doctor had diagnosed the case, the father came, and, knowing the fact that the child was not out of the cradle, he (the father) thought that the breaking of the bone was not possible, and did not believe the doctor. I was called and carefully examined the child. In this connection, let us remember the fact that in childhood a careful physical examination is the only reliable evidence of the presence or absence of disease or injury. In my examination I found an oblique fracture of the upper third of the femur of the right limb, and I told the father that the doctor was correct; that there was a broken bone and it must be set. I applied a temporary splint, and the next morning the ambulatory dressing. I examined the child the other day, and find that there is no shortening, and there is no limp.

Case II. A boy, three years and four months old. On July 18th, 1898, at 4 P. M., I was called to see this little patient,

and found him on the table. The history which the mother gave me was as follows: Frank was playing in the hall on the third floor; the window was open which led into the space between the two houses, which was about two feet in width. Frank fell out through this window to the ground between the houses. I examined the child, every bone separately, and found oblique and somewhat longitudinal fracture of the upper half of the femur. I reduced the fracture and applied a temporary splint. After my call another doctor was called in, he being the family physician, to treat the case. On July 20th the mother came to my office and told me that the family doctor would not assume the responsibility of this case, and asked me to take charge of the child. On July 20th, with the assistance of the family physician, I applied the ambulatory dressing.

Case III. A boy, 17 years of age. He was treated at the West Side Hospital by the ambulatory splint. The day after the splint was applied he was out of bed, and six weeks after the accident occurred I exhibited him before a meeting of the Chicago Medical Society, and allowed him to walk without any assistance. There was perfect union of the femur.

I have used the ambulatory method of treatment in 14 cases of fracture of the femur in my private practice, and in 6 cases at the Cook County Hospital. In all of these cases the results have been very successful.

I also use this appliance, that is, a combination of the plaster-of-Paris, the steel bar, and traction in cases of congenital dislocation of the hip joint. I have two cases at present in my private practice, one two years of age, and the other three years of age, both of whom I showed to the students of the Chicago Clinical School. I have put on one dressing in a case of fracture of the femur for Dr. Harvey, at the Cook County Hospital. The youngest patient I have treated by this method was a new-born babe, and the oldest, seventy-three years of age.

By the application of this dressing we avoid late union, atrophy of the muscles, hypostatic pneumonia, which is so danger-

ous in old persons, and to a certain extent we avoid delirium tremens, which is not apt to occur by the ambulatory method of treatment.

### WHAT CURES?\*

B. B. GRIFFITH, M. D., SPRINGFIELD.

This question arose in my mind, when reading some time ago two articles that appeared in the current medical literature. One was entitled "Why not be frank with the public?" the other was on "Faith Cures." What I have to say pertains to the character of cases seen daily by the general practitioner of medicine.

Since the beginning of time, the curing of disease, as most commonly accepted, has possessed a peculiar attraction and fascination for the human mind. A complete solution of this interrogation would necessitate an exhaustive review of the entire history of medicine, which the time allotted will not permit of. It will suffice for our purpose, however, to simply notice some of the early practices. We find the early practice of the art of curing disease swamped in Superstition, Ignorance and associated Religious ceremonies, one or the other factor playing the more prominent part according to the times, mental characteristics of the people, or fashion; influenced also by the conception prevailing among the healers, as to the cause of disease. That usually these followers of the healing art, and the patients themselves, believed implicitly in the practices followed we have no reason to doubt. Cures were effected by conjuring the evil spirit out of the body diseased, or in some way placating an enraged deity whose displeasure, it was supposed, manifested itself in this affliction. Failure to placate or cast out the evil spirit was accepted as we are expected to accept the inevitable, although probably then, as now, in the event of a liability of failure on the part of the healer to cure, another would be sought for.

These primitive healers also knew something of the medicinal properties of roots and

herbs. In the preparation and administration of these remedial agents there was always a degree of mysticism and secrecy, something of the supernatural. Superstition, reverential awe, or some similar mental characteristic has, and always will occupy, a prominent place in the mind of the laity, regarding the desired or anticipated effect of administered therapeutical remedies. In the natural acquisition of knowledge and experience, the materia medica was increased. The results obtained from the drugs used were carefully noted and the therapeutical knowledge acquired while limited was fairly accurate.

Two conditions, environment, and the theory of survival of the fittest, saved the early members of the human family from some of the ills incident to living. The remedies utilized by the early practitioner or medicine were gathered and prepared by themselves, or some one selected, who was acquainted with their physical properties. These roots, herbs, etc., were to be collected at certain seasons and under certain astronomical conditions. The method of preparation for use, was a secret of the individual, family or tribe, and this knowledge was handed down as a legacy from one individual or tribe to a successor. In this way the practical value of their remedies became pretty well known to them, and this knowledge stimulated the investigators to further research, and after repeated trials, if proven satisfactory, it found a place with other tried preparations and became a remedy to use for like ailments in the future. Individuals receiving medical administration under these circumstances, could not help but be impressed by the seemingly great wonders that these potent potions were about to accomplish in their individual case. Then, as now, quite a percentage of the people pinned their faith in being cured to the simple taking of medicine. The profession realize, that a large amount of prescribing which they are called upon to do, and render for a compensation, is not absolutely necessary, yet so imbued is the public mind with the idea that some medicine taken or applied will cure any or all

\*Read at the 52d Annual Meeting, Quincy, May 21, 1902.



complaints, we are often compelled to consider it as a means to an end, or a factor, in curing either real or imaginary disease. It is hard to impress the public with the truth that nearly all sickness is the sequence of some violation of the laws of nature or of ignorance. Owing to the cumulation of experience from the continued use of their remedies, the followers of the healing art knew more about their therapeutical action and medicinal properties than of the pathology of the condition for which they were administered. In this way the treatment of diseased conditions easily drifted into the treating of symptoms, or empiric medication, which even today has quite a secure hold upon the public as an important factor in effecting a cure. The impressions produced upon the patient when subjected to a thorough examination for some obscure, or chronic ailment, are varied and cannot be accounted for. The effect produced is similar to that arising from what theatrical people term "stage business." Frequently every move and expression of the examiner is given some interpretation, all questions asked are thought over afterward, the patient wondering why they were asked. Should the examiner unguardedly make some remark about the ease, especially if bearing on the prognosis, it is seized upon, and twisted and turned to suit the vagaries of an impressionable imagination. You frequently hear patients express themselves as feeling so much better after the customary visit of the physician, even when no medicine has been administered. This can be attributed to but one cause, the important role that the mental condition plays in assisting to cure mankind of his ailments, and is brought about by the personality of the medical attendant. There are psychological factors more or less marked that must be considered when treating those either suffering from sickness produced by pathological changes, or those who are victims of some of the various reflex neuroses.

The naming of the disease carries with it much importance in the estimation of the laity. Very frequently the first question asked of the medical adviser is "What is the

matter?" With the expectation that the ailment will receive a name. This very conclusively demonstrates the relative importance that the question of diagnosis occupies in the public estimation. Fortunate is the physician who early in his professional experience learns the importance of giving a non-committal diagnosis, yet with it all is truthful in his answers to such questions. Probably the next most frequently asked question is "Will I get well?" This also requires the same tact in answering as the former question, for the reason that patients are apt to misinterpret the answers given. Owing to the important bearing that an expressed opinion may have, one is sometimes confronted with a proposition where strict honesty is not always the best policy. We all know that individual nerve, grit, or pluck, has carried many a patient through what apparently was a fatal illness, and this factor, sometimes so essential in affecting a cure, must not be impaired. The ability to arouse and exert one's inherent resistance to the utmost, is oftentimes of the greatest aid in affecting a cure. The treatment pursued, ordinarily, gives the patient little concern, although generally, even in the most ordinary cases, having much to do with securing the desired result. As a rule, all persons who are sick or imagine themselves so, insist on taking medicine, and it is well for us that they do. Nearly every old woman or grandmother knows an infallible remedy for nearly every human ailment, and they are all sure cures, with some failures. I know of a physician who in his early practice was called into the country quite a distance. He had to go horseback, the ground was frozen but hardly sufficient to sustain a horse's weight. Arriving after this laborious trip he examined the patient, decided what was the matter and turned to get out his medicine case. The mother asked him what ailed the patient, he replied "It was a case of Pneumonia, and he would fix him up some medicine." The mother informed him that it would not be necessary to dose out any medicine for Johnnie, all they desired the Doctor for was to know what ailed him—Grannie would treat the case. With the

era of more correct reasoning, scientific investigation, and research, and the knowledge obtained therefrom, we are unquestionably making the practice of medicine more and more of an exact science, particularly is this true of curing disease, that part of the practice of medicine in which the public are most interested. As we become acquainted with the causes of disease and the pathological conditions produced thereby, we find that in many instances our predecessors employed remedies empirically that accomplished the desired results, but they did not know the true reason. We employ the same remedies today, because they are indicated and we have not been able to improve on them. In a like manner we today secure desirable results in the treatment of some diseased conditions, of whose etiology and pathology we know comparatively little. A very great aid in affecting cures, at our command, is the careful and thorough study of the individual patient as an entity, separate from the diseased condition for which treatment is sought. From the close observation of the frailties, short comings, and susceptibilities of the human family, have arisen the many dogmas and isms which the 19th century has bequeathed as a legacy to the 20th. Some of these in themselves apparently harmless, yet are not the cures all claimed. Most frequently they are originated for the purpose of restocking the usually depleted exchequer of the originator, which it is generally understood, they have in some instances handsomely done. What objection can there be to the regular profession utilizing in a legitimate way these aids in his work? Too often it seems to me we are prone to take into consideration only the pathological or diseased condition, and leave out the individual or patient part of the proposition. The fact that the ego of the patient is worthy of our consideration in affecting cures, has been thoroughly proven to my satisfaction when listening to the histories of those afflicted, who after having been the rounds of the medical profession with only indifferent benefit, claim to have been perfectly cured of the indisposition from which they suffered, by either the faith

process, the twistings of the osteopath or some similar hocus pocus, which depends largely for its existence, upon the fact that the patient is more thoroughly studied and better understood than the disease for which he applies for advice and relief. Fashions in medical treatment have an alluring fascination for quite a number, and as a rule these people are benefitted by a change. Civilized people have added much to their sum total of physical happiness by adopting improved hygienic methods of living, probably in many instances the user not knowing why they pursued certain plans except that it was the thing to do, as a fad. After all, nature is the great healer, and it should be our constant effort to aid her in her work, and imitate her in the processes she endeavors to establish in the curing of disease. He who can best interpret nature's wants and assists in removing the cause of the diseased condition will have the greatest number of cures to his credit.

In conclusion briefly answering this question, I would say the essentials for a cure are, a correct diagnosis, have a true conception of the pathological condition existing. The adoption of a course of medication in harmony with modern teaching. Attention to dietetics and correct hygienic surroundings. At all times, in the consideration of the case, not to neglect to take into consideration the individual. Thus it seems to me will we be most successful in accomplishing our aim to cure mankind of his ailments, and if that is impossible, at least contribute to his physical comfort.

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#### THE WORK OF THE STATE BOARD OF HEALTH.

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BY WARWICK A. SHAW, CHICAGO.  
Attorney for the Illinois State Board of Health.

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In 1877 the Illinois State Board of Health went into being by virtue of the Legislative enactment of that year. The provisions under which the State Board of Health was organized were very broad in their character and gave the Board general supervision over the interests of the health and life of the

citizen of the State. The Board was given by that Act charge of all matters pertaining to quarantine and authority to make such rules and regulations and such sanitary investigations as might from time to time be deemed necessary for the preservation or improvement of public health.

It was also provided that it should be the duty of all police officers, sheriffs, constables and all other officers and employes of the State to enforce such rules and regulations so far as the efficiency and success of the Board might depend upon their official cooperation.

There was, however, also another law enacted in 1877 giving the Illinois State Board of Health power to regulate the practice of medicine in the State of Illinois with extraordinary penalties thereto attached. Under this law the prosecution for practicing medicine without a certificate from the State Board of Health was a fine of from \$50 to \$500, or 30 to 365 days in jail or both, and the prosecution was to begin by arrest. But in 1887 this law was repealed and another law enacted of a similar character, which provided that any person desiring to practice medicine must present his diploma to the State Board of Health for verification and if found genuine and from a legally chartered medical institute in good standing, the State Board of Health should issue a certificate to that effect, which should entitle the holder to practice medicine. It also provided that if not a graduate the person practicing medicine in this State should present himself before said Board and submit himself to such examination as the Board might require, and if the examination be satisfactory, the Board should issue its certificate and the lawful holder of such certificate should be entitled to practice medicine.

Three forms of certificates were allowed to be issued; one for those having diplomas or licenses, one for those examined and passed by the Board and the third, one for those who had been practicing medicine continuously for ten years within the State prior to the taking effect of the Act of 1877, and who had not under said Act of 1877

obtained a certificate to practice medicine, provided said application for such certificate be made within six months of the taking effect of that Act. The Act of 1887 also provided for certain fees to be paid for a certificate and also provided for fees for examination for non-graduates. It also defined the practice of medicine to be as follows: "Any person shall be regarded as practicing medicine within the meaning of this Act who shall treat, operate on or prescribe for any physical ailment of another, but nothing in this Act shall be construed to prohibit services given in cases of emergency, or the domestic administration of family remedies, and this Act shall not apply to commissioned surgeons of the United States Army, Navy or Marine Hospital service in the discharge of their official duties." It provided for the licensing of itinerant vendors of any drug or nostrum, ointment or appliance of any kind intended for the treatment of diseases or injury who shall, by writing or printing or in any manner, profess to cure or treat diseases or deformity, which license should be at the rate of \$100 per month to be paid into the treasury of the Board. Any itinerant vendor violating the said provision to be fined not less than \$100 and not exceeding \$200 for each offense.

A penalty was also provided of a fine of \$100 for the first offense and \$200 for each subsequent offense to be recovered in an action of debt for the violation of any provisions of said Act regarding practice of medicine or surgery, and that upon conviction the courts should, as a part of the judgment, order that the defendant be committed to the county jail until fine and costs were paid, and it provided also for appeal by the defendant or by the plaintiff, but that the plaintiff need not file an appeal bond, the form of the action being the People of the State of Illinois, for the use of the State Board of Health, against the defendant.

After operating under the Medical Practice Act of 1887 it was found that the requirements for obtaining a certificate were not sufficiently strict to obtain the best results for the advancement of the standing



of the profession in the State of Illinois. In other words, it was deemed that the grade of the profession might be greatly elevated by more strict requirements for a certificate in 1899, hence the law of 1887 was repealed by a new Act which went into force July 1st of that year, 1899. This Act requires that a diploma shall be required before examination be given by the State Board of Health and that the diploma shall be from a college or institution in good standing as may be determined by the Board. It provides that a certificate may be refused to individuals, who have been convicted of the practice of criminal abortion or who have by false or fraudulent representations obtained or sought to obtain practice in their profession, or by false or fraudulent representations of their profession have obtained or sought to obtain money or any thing of value, or to advertise under names other than their own, or for any other unprofessional or dishonorable conduct, and the Board may revoke such certificates for like cause, and provided also for a hearing before the Board.

This gives the power to the State Board of Health to revoke any license issued under the Act of 1899, for any persons acting unprofessionally or dishonorably or for any of the causes above mentioned.

The definition of practicing medicine in the Act of 1899 is practically the same as that of 1887, and is as follows:

"Any person shall be regarded as practicing medicine within the meaning of this Act, who shall treat or profess to treat, operate on or prescribe for any physical ailment or any physical injury to, or deformity of, another: Provided, that nothing in this section shall be construed to apply to the administration of domestic or family remedies in cases of emergency, or to the laws regulating the practice of dentistry or of pharmacy. And this Act shall not apply to surgeons of the United States army, navy or marine hospital service in the discharge of their official duties, or to any person who ministers to or treats the sick or suffering by mental or spiritual means, without the use of any drug or material remedy."

The balance of this Act is practically the same as that of the Act of 1887, except that the jail sentence is limited to 30 days in case of non-payment of fine in the first offense and to 90 days for each subsequent offense.

Under the Medical Practice Act of 1899, and the general law of 1877 the State Board of Health is operating at the present time and in addition thereto there are other laws worthy of mention, two of which give the State Board of Health power over lodging houses and the registration of deaths and births. The treatment of physical ailments by a person not licensed by the State Board of Health has been recognized as a menace to the welfare of the health of the people of the State and the law regulating the practice of medicine, although drastic in its character, is certainly a necessary and proper provision for the protection of the citizens of Illinois.

Under the provisions of this Act various classes of healers are being prosecuted throughout the State. As these prosecutions are practically the same in every county, it will be perhaps the most satisfactory manner of considering this subject to present to you a statement of the work of the State Board of Health in the County of Cook where the prosecutions are the most numerous. These healers cover a variety of classes; first, there are those practicing by medicines and drugs, some of them holding themselves out as physicians with the title of "Physician" or "Doctor," and some of them to avoid notice and prosecution, who though they are actually practicing and prescribing, yet who do not use the name of physician or doctor. It is frequently a close question of law as to whether such persons are coming within the definition of practicing medicine and the question again devolves upon the definition of the Act of 1899, as to what amounts to treating the physical ailments of another. Where such violators are holding themselves out as doctors and physicians there is very little trouble in establishing their legal status, but where they are dispensing medicine in many instances they claim the privilege so to do as being practically in the same

line as that of druggists, claiming that if they are violating any law that it is that of the Pharmacy Law. In such cases it is necessary to prove that they are prescribing and examining into the condition of their patients before obtaining a conviction.

In the second class of cases we may place magnetic healers and mental or spiritual healers using material means, that is, magnetic healers who are under this guise treating by manipulation and so-called osteopathy by application of rubbings to affect the nerve centers and causing the flow of blood to such parts as the healer deems necessary to effect a cure. These and the mental healers who are operating in the same manner, come within the rule laid down by our Supreme Court in the case of *Gordon vs. The People*, which has recently been decided, where it is held that a magnetic healer who manipulates the human system for cure and is holding himself out as a physician is acting in violation of the Medical Practice Act.

Third, Persons engaged ostensibly in treating human ailments by mental or spiritual means who are using medicines.

Fourth—Criminal use of surgery and criminal use of medicines by midwives licensed or unlicensed, and who are doing so in violation of the statute of 1899, as midwives are not entitled to the use of surgery or medicines in their practice under our Act, and here I would say that an amendment to the criminal law might well be made to meet the deplorable conditions existing in this line of criminal work, whereby the courts should be authorized upon the recommendation of the State's Attorney to have entered upon the record of every criminal abortion case an order that any victim testifying against the physician, midwife or other person committing the crime, should be exempt from prosecution upon turning state's evidence. It would also be a step in the right direction to establish control of all confinement cases under the supervision of the state government and in furtherance of this the licensing and control of lying-in hospitals by the State, and the establishment of certain regulations, maintaining the secrecy as to the names of inmates, and the requiring of all

confinement cases to be placed under and within such institutions or control of licensed persons absolutely under the supervision of the state, except within the domicile of the individual, provided a law can be so constructed as to come within the constitution and at the same time effect desirable results. The evil is so appalling, especially in large cities, that it calls for an effort on the part of the Legislature to reach it, provided it can be done with safety to the rights of individuals, and provided also a law can be so constructed as to make evasion thereof impossible.

It is impossible for the State Board of Health to prosecute any cases of criminal surgery in instances where licensed physicians are so making a misuse of their profession, as there is no provision in the Medical Practice Act for so doing. The only provision which will reach such cases is that already mentioned of revoking licenses where they have been issued under the law of 1899, hence the prosecution of such cases falls entirely to the work of the State's Attorney in the various counties and in most instances there is no interference with this class of criminal practice by reason of the difficulties which surround the obtaining of evidence against the offenders. Provisions should therefore be made, if deemed advisable, whereby a special power shall be given to the State Board of Health to begin the prosecution of such cases before justices for investigation, so as to place the matters in the hands of the State's Attorneys, as it is impossible for the State's Attorney in large counties with the appropriations which he has, to prosecute cases in justice courts.

It would seem that in the interests of morality this work should be especially considered by the next Legislature and appropriations made for the detection and the prosecution of this class of criminals, with the necessary legislation to make the evidence possible. The framing of such bills would be a matter of careful consideration on the part of the legislators and would require the most minute examination upon the part of the drafter of such laws. The experience of the State Board of Health has been that

while their attention has been called to such violations of the law, yet the positive evidence has been lacking, although knowledge of its existence has been forcefully presented to its attorney by reason of advertisements found in certain daily papers which from their character indicate the line of work that is being done, and yet from which no satisfactory evidence could be obtained sufficient for conviction. There is a field for the State Board of Health in the line of eradicating from the profession this most dangerous and disreputable class of practitioners, who I am happy to say, are in the extreme minority and infinitesimal, in number as compared with the balance of the profession.

Fifth—There is a class of spurious healers which call for passing notice only, and that is the complexion, scalp and facial artists, who although technically treating, are nothing more than beautifiers in their work. Thus far no attempts have been made to regulate this class of persons, except where use of the knife has been indulged in or masseur work in the line of the Gordon decision, with or without the use of the term "Doctor" or "Physician," as the intent of the statute is not evidently directed toward this class of people, and under the same category might be included those persons who are using electrical machinery for the benefit of human ailments, for the decision of the Supreme Court in the case of *People vs. Lehr*, recently decided, holds, as the Appellate Court before it held, in the same case, that the sale of mechanical devices does not constitute the practice of medicine and while the application of mechanical instruments like the use of electricity and electrical instruments is in one sense different from that of the sale of the oxygenator, yet the statute is not so constructed as to cause us to believe that it was intended to reach this class of cases.

Sixth—In the case of the treatment of the eyes by optical experts by the application of glasses, the Appellate Court has held that such treatment does not constitute the practice of medicine. These cases, however, do not include the practice of an opti-

cian giving remedies or treatment to the eyes by drugs.

In case any amendments are made to the Medical Practice Act, doubtless provisions might be made for controlling the particular branches which are not at the present time clearly covered by the law of 1899, in such plain terms as to leave no question as to their scope. For instance, there is no reason why examinations should not be required in cases of persons fitting glasses and advising as to the eyes, as well as those who are administering medical treatment to the eyes, provided the statute shall clearly cover such a class of practitioners. The question may sometimes arise in the public mind as to the reasons for permitting the advertisement by physicians of their business through circulars and the public press. For those who are not acquainted with the law of 1899 it will be sufficient to say that no provision was made whereby licensed physicians are prevented from advertising their business and it is doubtful whether or not such a provision would be constitutional. Hence no interference can be made with these advertisements, provided they are not in the line of criminal practice, and only then when the advertisements are so distinct and clear as to leave no reasonable doubt as to the intent in the minds of the jury. There is a popular feeling of sympathy existing among the people at large against prosecutions of quasi-criminal cases, under which class those cases prosecuted by the State Board of Health under the Medical Practice Act, come, hence it is a difficult thing at times to enforce the law against the offenders, because of the fact that the sympathy of the juries is aroused by appeals of their attorneys to their prejudices in favor of the individual rights of man to earn his living as he sees fit, in spite of which tendency prosecutions have been followed up with vigor and to a large extent the practice of medicine has been discouraged and uprooted among that class who are not licensed or who being licensed as midwives, are practicing as physicians. The standard of those now being admitted to the practice of medicine in the State of Illinois has been gradu-



ally but steadily improving and is now of a very high order. Under the rules of the State Board of Health a four year's course being now required in colleges to make them of good standing. This work of the State Board has been very conscientiously carried out. Examinations are held four times in the year and the examinations show constantly an increase of proficiency by reason of the high grade work being done in the colleges.

The interest which physicians have shown in this State in the elevation of the profession has done great things in this direction. Discussion at meetings, banquets and conventions of the medical societies have contributed greatly to the advancement of this work and to the upholding of the standard of the profession. I would especially call the attention of the medical profession to the necessity of co-operation in eradicating from their midst unlicensed persons who are practicing medicine and would say that in all cases where this co-operation is extended the State Board of Health preserves absolutely inviolate all communications made to them pertaining to such matters and it is only by the aid and assistance of the profession that a full measure of success may be obtained in ridding the public of so-called professional persons who are practicing without a license.

The sanitary work of the Board is conducted directly from Springfield by the Secretary of the Board and the work of protecting the citizens of the State from infectious and contagious diseases has been eminently successful under the present management and most forcefully administrated. In many cases quarantine has been made, fumigation and vaccination insisted upon wherever it could be done within the law and to an extent that is perhaps very little appreciated by those who are not so situated as to be conversant with the facts. The keeping of the records of physicians and midwives, enforcing of the statistics law of births and deaths by registration, preparing statistics and the constant study of the changes of laws and regulations in other states and the advancement of the general

work of the Board, require an amount of labor and patience which perhaps would be little understood by any but those in the profession, and in addition thereto the Legislature has imposed the duty upon the State Board of the visitation of lodging houses and the enforcement of the provisions compelling the keepers of lodging houses to regulate their room space in accordance with the rules of health which necessitates a large inspection force in the city of Chicago.

Many questions are constantly arising pertaining to the rights of individuals under the laws controlling the health of the State, which must be from time to time determined and these matters are constantly under consideration by the officers and attorney of the Board and from time to time considered by the Board at their regular meetings. The work of State Boards of Health is as yet practically in its infancy by reason of the constant changes of conditions. The powers of the Board, though extraordinary at the time, could with the advantage to the interests of the life and health of the citizens in this State be greatly increased in many directions. The tendency of the courts has at times been to diminish rather than to increase the powers of State Boards. Nevertheless the Supreme Court of this State has thus far placed practically no material limitations upon the powers of the Board as given by the Legislature, and although the rights of the individual in vaccination cases has been to some extent upheld by the Supreme Court in its decisions and while it is impossible to pass any laws which will compel a citizen to submit to vaccination, yet there is no question as to the right in times of epidemic in the State, city or county of offices properly organized to prohibit the meeting of great masses of persons to the extent of endangering life and health, but to establish this right there must also exist as a condition preceding, an epidemic sufficiently great to be of danger to the community and the question as to whether there is an epidemic of that character must necessarily be a question of fact. The work of the State Board of Health must necessarily be in the line of advancement

of the interests of the life and health of the citizens of the State to follow out its objects. In this work, which I believe is being carried out conscientiously at this time, I would urge and bespeak for the Board in its work the same hearty co-operation on the part of the physicians of the State of Illinois that has been accorded to it in the past and I believe I am authorized in assuring you that in the future as hitherto, it will be the aim and the effort of the State Board, both as an institution and as individuals, and by its officers at all times to carry out and subserve the best interests of the life and health of the citizens of this State and in the administration of the Medical Practice Act to effect a higher and grander standard in the profession even than has been achieved in the past, that the great profession of medicine and surgery shall ever stand for those high ethics and humane principles which have made famous the names of thousands of the disciples of the noble profession of which you are members.

### THE HEART AND LIFE INSURANCE.\*

BY J. C. SULLIVAN, M. D., CAIRO.  
Member State Board of Health, Illinois.

We frequently hear the remark that Mr. A. was rejected by Insurance Company B. on account of heart trouble; whereas it was not the Company but its stony hearted Medical examiner, who governed by cast iron rules make no exception whatever thereby doing a great wrong to many a poor widow and orphan.

Examination for life insurance is always a matter of practical importance to the busy practitioner, hence all information that will guide him in the construction of a blank is acceptable.

As by a hasty or superficial scanning of the applicant he may be predisposed on account of a healthy appearance, to overlook some lurking malady and saddle on the company a risk that at no distant day will prove a gross imposition.

Or, by not being sufficiently posted may do an incalculable injury or damage to the

applicant's family not alone in this case in refusing to recommend but in thus debaring him from all other companies or associations, until some examiner more proficient may explain to the satisfaction of his company why he is a safe risk.

As the heart and lungs are so intimately connected and are both so badly abused by alcohol and tobacco which seemingly does not affect the applicants' appearance as to general health still we must remember that a good health may not be a good risk for any pronounced disproportion of height and weight rejects no matter how healthy the applicant may appear.

The death rate in the majority of all insurance companies, and in *all* the mutual associations, one-third is from consumption and one-sixth from alcohol. Thus one-half at least are from causes that should be apparent to the agent or the chief examiner, but unfortunately *these* and the family history are left to the tender mercies of the local examiner who after careful and conscientious investigation reports to the chief Medical referee and the benefits of the doubt are given to the *company* and *not* the applicant.

Hence the justice of time, care and thoroughness is apparent in all examinations of those who place their and their families interests in our hands.

Many have refrained from applying for insurance on account of a supposed or an erroneously diagnosed case of heart disease and consequently have left their families almost penniless at their death whereas dollars in the thousands should have been theirs.

Singular though it seems to the laity the greatest and more noted heart disturbances which gives the greatest alarm are those in which no anatomical lesions exist, and in which no mechanical cause is discernable. Palpitation or tachycardia is the most noticeable which when paroxysmal is also sudden, very alarming especially when the pulse increases from normal to 84, to 180 or even 240 per minute without any irregularity or intermission and followed by a passage of a large quantity of clear limped urine of low specific gravity (generally termed nervous water). Its causes have been assigned to

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

the mind, fright and errors of diet but those best established are bodily and cerebral overwork. It has been observed that the college graduate of today finds it hard work to lead a sedentary life with the heart of an athlete constantly working like a force pump. Tobacco has also great influence not only from the nicotines being in the system but also from its influence on the red corpuscles themselves which under the microscope resemble an old fashioned ginger cake being serrated at their edges and acting as five million buzz saws to each cubic centimeter of blood of the heart's contents.

Bulbar Neurosis has been given as a cause but no anatomical lesion even on microscopic examination of the nerves has ever given any endorsement to this theory. That if fibrinous deposit was assigned as a cause but in as much as a myocarditis is very rarely accompanied by tachycardia gives doubt to this. That deposits of fibrin have been found in the walls of the muscles and trabeculae of the papillary muscles of the left ventricles give rise to the opinion that some regions of the heart are tolerant while others are not. The latter are found to be the intraventricular walls and papillary muscles which further shows that the heart is more automatically supplied with nerve centers than is generally taught and accounts for the paroxysmal tachycardia, due to the ptomaines and leucomaines of intestinal putrefaction.

Bradycardia is a symptom and not a disorder and is applied only when the pulse is below 60 while some authors claim 40 as the zero mark.

That all functional may become an organic disease is possible but not probable as it but very seldom happens and no certainty that they were not coexistent when examined for if we have a disturbed rhythm paroxysmal in character with an interval of normal pulse, the condition is functional while if the rhythmic disturbance be constant and associated with vertigo or syncope the disease is organic as a rule.

The murmurs and bruits so well known and with which the practitioner so frequently meets are the points of discrimination which the examiner uses in rejecting

or recommending in life insurance and are hence his test cases. If experience be of any value the following I think should have weight. Sir Andrew Clark of England concluded from 684 cases of personal observation, first, that there are many people with long standing valvular disease of the heart engaged in the active business of life without any symptoms of heart disorder. That they have enjoyed good health and have reached an advanced age.

Second, that Mitral regurgitation murmur so often met with in chorea for the most part disappear within eight years after the attack.

Third, that the valvular inflammations and their effects arising in the course of rheumatic fever do sometimes disappear and leave no clinical evidence of their former existence.

Fourth, that the signs of valvular defects arising from degenerative changes of middle life do also on rare occasions when circulatory and respiratory disturbances accompany them at commencement subside and permit of complete re-adjustment (apparently) hence if mitral disease exists independently of any degeneration of the heart and if it has existed two years, if the ventricles be in good order and the arteries sound, if there be no persistent basic congestion nor recurrent hepatic congestion, and the general health is good, then this mitral disease will not shorten life.

Bristow and Clifford Allbut of England referees both recommend as good risks such cases of mitral regurgitation and valvular disease, when alcohol is avoided.

Then as a summary we may class as good risks,

All those whose pulse are regular and not above 84.

All those whose pulse are regular and not below 60.

All those with valvular defects when compensating hypertrophy is coexistent.

All those with valvular defects which have existed two years and when the lungs and liver are healthy and the applicant is not addicted to the tobacco habit and when alcohol in any form is avoided.



# The Illinois Medical Journal.

The Official Organ of the State Medical Society.

EDITOR—George N. Kreider, A. M., M. D., Springfield.

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Douglas County—W. E. Rice, M. D., Tuscola.  
DeWitt County—J. H. Tyler, M. D., Clinton.  
Edgar County—H. McKennan, M. D., Paris.  
Edwards County—J. H. Lacey, M. D., Albion.  
Fayette County—Asa L. T. Williams, M. D., Vandalia.  
Franklin County—W. H. Smith, M. D., Benton.  
Fulton County—D. S. Ray, M. D., Cuba.  
Gallatin County—Geo. P. Cassidy, M. D., Shawneetown.  
Green County—H. A. Chapin, M. D., Whitehall.  
Grundy County—H. M. Ferguson, M. D., Morris.  
Hancock County—R. L. Casburn, M. D., Carthage.  
Henderson County—W. D. Henderson, M. D., Biggsville.  
Henry County—W. H. Watrous, M. D., Galva.  
Jackson County—Wm. C. Hill, M. D., Murphysboro.  
Jersey County—A. K. VanHorne, M. D., Jerseyville.  
Jo Daviess County—D. G. Smith, M. D., Elizabeth.  
Johnson County—J. E. McCall, M. D., Vienna.  
Kankakee County—J. A. Brown, M. D., Kankakee.  
Kendall County—R. A. McClelland, M. D., Yorkville.  
La Salle County—W. A. Pike, M. D., Ottawa.  
Lake County—A. G. Haven, M. D., Lake Forest.  
Lee County—E. S. Murphy, M. D., Dixon.  
Livingston County—Jno. Ross, M. D., Pontiac.  
McDonough County—R. E. Lewis, M. D., Macomb.  
McLean County—E. S. Reedy, M. D., Bloomington.

## DISTRICT SOCIETIES.

Aesculapian—H. McKennan, M. D., Paris.  
Brainerd District—J. L. Lowrie, M. D., Lincoln.  
Central Illinois—F. J. Eberspacher, M. D., Pana.  
Galva District—C. W. Hall, M. D., Kewanee.  
Fox River Valley (Kane and McHenry Counties)—F. H. Jenks, M. D., Aurora.  
Military Tract—C. B. Horrell, M. D., Galesburg.  
North Central—Geo. A. Dicus, M. D., Streator.  
Southern Illinois—E. E. Fyke, M. D., Olney.  
Tri-County—Leroy Jones, M. D., Hoopeston.  
Western Illinois—H. A. Chapin, M. D., Whitehall.

## URBAN SOCIETIES, EX CHICAGO.

Alton Medical Society—Geo. E. Wilkinson, M. D.  
Decatur Medical—Lynn M. Barnes, M. D.  
East St. Louis—C. W. Lillie, M. D.  
Jacksonville Physician's Club—D. W. Reid, M. D.  
Peoria Medical—C. U. Collins, M. D.

Macoupin Co.—J. Palmer Matthews, M. D., Carlinville.  
Marion County—E. E. Fyke, M. D., Centralia.  
Marshall County—W. G. DuFour, M. D., Speer.  
Massac County—C. E. Trovillion, M. D., Metropolis.  
Mercer County—A. N. Mackey, M. D., Aledo.  
Montgomery County—J. M. Trigg, M. D., Farmersville.  
Morgan County—T. A. Wakely, M. D., Jacksonville.  
Knox County—G. S. Brown, M. D., Galesburg.  
Ogle County—H. A. Mix, M. D., Oregon.  
Perry County—J. W. Smith, M. D., Pinckneyville.  
Pike County—R. H. Main, M. D., Barry.  
Pope County—W. S. Dixon, M. D., Rosebud.  
Pulaski County—Chas. J. Boswell, M. D., Beechwood.  
Randolph County—H. C. Adderly, M. D., Chester.  
Richland County—M. E. Poland, M. D., Olney.  
Rock Island County—G. L. Eyster, M. D., Rock Island.  
Saline County—J. R. Baker, M. D., Harrisburg.  
Sangamon County—P. L. Taylor, M. D., Springfield.  
Schuyler County—A. W. Ball, M. D., Rushville.  
Scott County—J. P. Campbell, M. D., Winchester.  
Shelby County—A. G. Mizell, M. D., Shelbyville.  
Stark County—M. T. Ward, M. D., Toulon.  
Stephenson County—R. J. Burns, M. D., Freeport.  
St. Clair County—B. Portuondo, M. D., Belleville.  
Tazewell County—C. G. Muehlman, M. D., Pekin.  
Union County—T. Lee Agnew, M. D., Anna.  
Vermilion County—E. E. Clark, M. D., Danville.  
Wabash County—J. B. Maxwell, M. D., Mt. Carmel.  
Warren County—W. H. Wells, M. D., Monmouth.  
Washington County—J. J. Troutt, M. D., Nashville.  
Whiteside County—P. F. Purdue, M. D., Lyndon.  
White County—W. A. Steele, M. D., Carmi.  
Will County—Herbert S. Worthley, M. D., Joliet.  
Williamson County—G. W. Evans, M. D., Marion.  
Winnebago County—S. R. Catlin, M. D., Rockford.

## COOK COUNTY SOCIETIES.

Chicago Medical Society—F. X. Walls, M. D.  
Aux Plaines Medical—W. R. Livingston, M. D., Maywood.  
Electro Medical—T. P. Hall, M. D.  
Evanston—M. G. McEwen, M. D.  
Gynaecological—R. W. Holmes, M. D.  
Laryngological and Climatological—J. E. Rhodes, M. D.  
Neurological—C. H. Lodor, M. D.  
North Shore—Geo. E. Baxter, M. D.  
North Side—Mortimer Frank, M. D.  
Orthopedic—Edwin W. Ryerson, M. D.  
Pathological—Geo. H. Weaver, M. D.  
Pediatric—Emma M. Moore, M. D.  
Physician's Club—L. H. Mettler, M. D.  
Southwestern—Thos. J. McGonagle, M. D.  
Southern—W. S. Harpole, M. D.  
Stock Yards—R. J. Tivnen, M. D.  
Surgical—A. E. Halstead, M. D.

All communications should be addressed to the Editor, 522 Capitol Ave., Springfield, Illinois.

The JOURNAL is published monthly. The subscription price is \$3.00 per annum in advance.

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MARCH, 1903.

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## THE NEW LAW CREATING A BOARD OF MEDICAL EXAMINERS.

In our supplement will be found the text of the new law regulating the practice of medicine in this state. The text has been approved by three leading jurists and is probably as near perfect as it can be drawn. There may be a few minor changes made before it is introduced on Tuesday, March 3d. When it is introduced it would be well

for each and every one of our readers to ask for a copy of the proposed law as printed by the state from his representative thereby showing that the profession is interested in this most vital subject.

\* \* \* \* \*

As finally completed and introduced the law does not contain the sections relating to the licensing of nurses. There are several reasons for this. In the first place

this matter has not been considered by the State Society, having come up since our Quincy meeting. In the second place this being an entirely new proposition it will undoubtedly meet some opposition, which would be reflected on that part of the bill regulating the practice of medicine against which there is little if any effective opposition. In the third place if the General Assembly and nurses see fit to have this function taken up by the new Board of Medical Examiners it can be done later on under the provisions of a new and separate bill.

\* \* \* \* \*

Never before has the profession of Illinois been so firmly united for the purpose of securing legislation as now. Nearly 2,000 influential citizens and representative practitioners of all schools known as the Legislative League are watching the course of events in the legislature and are ready to act on the call of the committee. This year there will be no such thing as putting out a skirmish line and then a retreat on the part of the main army. Woe be to the member of the profession who fails to respond to this call for duty. The interests of the profession now and for the coming century depends on faithful and united action at this time.

#### THE REGISTRATION OF BIRTHS AND DEATHS LAW.

As will be seen by a reference to another column several bills have been introduced calling for a repeal of the law requiring the registration of births and deaths. That the law has worked hardship in some instances is not to be denied but this would not seem to be a valid reason for repealing it entirely. The friends of the law are willing to have amendments made making it less burdensome, but will steadfastly oppose any more radical action. The following clippings from recent Chicago papers

would seem to indicate due appreciation of the law as it now stands. The second is an editorial from the Tribune.

Chicago health department officials are stirred by the Miller bill, for the repeal of the law calling for registration of births and deaths. Alderman Butterworth, chairman of the health committee, will ask the council Tuesday night to declare itself opposed to the bill. Secretary Pritchard says that among all records kept by the health department none are visited more frequently by the people than those affecting births and deaths.

#### Illinois Vital Statistics.

It is quite natural that the people of the thinly populated parts of the State should feel that the law with regard to the registration of deaths is hard on them. It really is inconvenient to travel all the way across a county in order to lodge information with the proper official. It ought to be possible, however, to abate the inconvenience of the law in its operation in the country districts without impairing its efficiency in other parts of the State. "Its efficiency" is an extremely respectful and even adulatory way of speaking about it. Illinois vital statistics have not yet reached a place which can be regarded as a pedestal. The things that were said about Illinois statistics at the Paris exposition are not reprinted with any great frequency in Illinois newspapers. If our law with regard to vital statistics needs anything, it is not relaxing but stiffening. The real cry is not for solvent but for starch.

It is a cause of continual mortification to Illinois people on their travels to find that in the matter of records, statistics, etc., Illinois falls so far behind many other parts of the world. Our factory inspector's office, for instance, is most inadequately manned, though it is well officered, and as long as this continues to be so Illinois will continue to be without a complete record and exhibit of its manufacturing establishments and the persons employed therein. And as with factory statistics, so with vital statistics. Illinois must soon address itself to the problem of producing vital statistics which will be of more service to the student and to the statesman. Meanwhile, however, there is no reason why a law which is really burdensome to country people should not be lightened for them. The records must be kept, but the means of securing the records can be so arranged that farmers will not have to spend an excessive amount of time hunting for county clerks.

#### THE GREAT MEETING OF DENTAL SURGEONS.

In February on the invitation of the Odontological Society of Chicago there was assembled in that city the greatest gathering of dentists ever known in this or any other country. Invitations, 23,000 in number, were sent to every practitioner in the United

States and Canada, and as a result nearly 2,000 of them attended this meeting. The profession in Chicago acted with commendable altruism. They turned the entire scientific program over to the distinguished visitors, four hundred of whom gave interesting and instructive clinics. \* \* \* \* The success of this meeting should be an inspiration to our committee of arrangements for our coming State meeting. In Illinois alone the number of physicians is nearly one-half the number of dentists in the whole of North America. The ten thousand practitioners of this State are now aroused to the importance of the work of the State Society and if they are properly invited to attend its session and proper railway arrangements are made for their cheap transportation quite 2,500 of them will attend. It will not be quite so easy to arrange for their scientific entertainment but we believe that intelligent effort on the part of the committee will result in a program which will be satisfactory to all concerned. It has been suggested that distinguished guests from other states hold the clinics but we fear it is a little late to make this arrangement. We are sure the committee will fully consider all these matters and finally succeed in presenting a program which will be a scientific feast to the guests and a credit to the great medical center within which the meeting is to be held.

\* \* \* \* \*

Before leaving this subject we wish to deprecate the expenditure of any great amount of money in entertaining the members of the State Society. The country members do not desire this. They wish to attend the meeting and feel free from a sense of embarrassment which a too lavish entertainment would entail. The receipts from the exhibitors should more than suffice to pay all the bills and put a neat sum

into the treasury of the Society as has been done during the past years by the meetings at Springfield, Peoria and Quincy.

#### MORTALITY STATISTICS OF ILLINOIS CITIES FOR JANUARY, 1903.

	Popul- ation.	Death Rate.	Diph- theria.	Scarlet Fever.	Measles.	Small- pox.	Typhoid Fever.
Chicago .....	1,820,090	16.32	4	4	4	4	4
Springfield ..	40,000	13.74	5	0	9	0	2
Jacksonville..	16,000	15.60	1	0	0	0	0
Freeport .....	13,258	26.15	0	0	0	0	0
Streator.....	14,079	4.8	0	0	0	0	0
Pontiac .....	4,266	2.8	0	0	0	0	0

Health Officer Holke of Freeport, reports two cases of diphtheria. No other cases of contagious or infectious disease. The general sanitary condition of the city is good.

Since January 1st the bulletins issued by the Chicago Board of Health have not contained the statistics heretofore published. Commissioner Reynolds has promised to give us these in the future. The commissioner has called attention to the great mortality due to pneumonia and urges that the same care be taken to collect and destroy the sputa that is taken in pulmonary tuberculosis, in diphtheria or influenza. Chief Medical Inspector Spaulding states that the type of smallpox now seen has changed from last year and that the marvelously low death rate of last year is not likely to be maintained this year. Several deaths have occurred, the first in six months.

#### COUNTY AND DISTRICT SOCIETIES.

Thanks to the activity of Chairman Hall the work of organizing county societies goes bravely on. A reference to our columns will show that Fayette and Edgar counties have been organized during February and Chairman Hall writes encouraging news concerning Madison and Cumberland counties. This month a report is made of the reorganization of Jackson County of which J. T. McNally of Carbondale, ex-president of the State Society is president. Eighty counties are now completely organized, show-



ing an increase of 100 per cent in three and one-half years.

\* \* \* \* \*

Unfortunately an idea has been entertained by some members of district societies that an effort is being made to abolish them. Nothing could be further from the truth. We have ventured to express an opinion that only one or two meetings a year are necessary for the district societies and that they should confine their efforts to scientific work and sociability alone, leaving the actual business of the profession to the organization which should exist in every county comprising the district. Farther than this we have never gone, but on the contrary believe that district societies have a mission in this State which can not be carried out in any other manner. Let the district societies continue and flourish, but let them undertake only that work which they are best fitted to accomplish.

#### THE TYPHOID IN CHICAGO.

It was hoped that the construction of the Drainage Canal would eliminate typhoid fever from Chicago, or at least lower the death rate from this scourge to a point commensurate with those of other large cities where pure drinking water has been obtained. The numerous impressive features of the great sanitary canal and the engineering problems involved in its accomplishment, have seldom failed to excite wonder in visitors of distinction and they are certainly responsible for a sense of pride on the part of the citizens of Chicago as well as the entire State. The prevalence of typhoid in Chicago during 1902, has therefore been a great disappointment and to many a surprise. No such epidemic has been experienced there since the memorable one of '1890-'92, although the disease has always possessed an important place in the mortality tables.

The careful review by Jordan<sup>1</sup>, of the reasons for its continuance and its recent calamitous increase does not leave much basis for the well-founded and widely-spread satisfaction over the completion and possession of the great drainage canal.

(1) Journal American Medical Association, 1902. XXXIX, 1561.

He shows that the sewage of a large part of Chicago is still emptied into Lake Michigan and that, even though the so-called "intercepting sewers" do succeed in diverting this danger from the water supply, there will still remain many other sources of possible pollution unconnected with the system of drainage into the Illinois river; nor is it likely that any plan will be adopted soon for excluding from the lake the sewage of the smaller towns on the shore of the lake, north of Chicago or of the places in Indiana adjacent to Chicago.

The sewage from the region about the Calumet River, a flourishing district containing over 70,000 people is largely augmented by numerous industries located upon the stream; it is carried into the lake by the river and forms an especial danger to the inhabitants of neighboring parts of Chicago whose water supply is drawn from the lake just north of the mouth of this stream. In the consideration by Jordan of the most effectual means adopted by other large cities for securing pure drinking water two facts become conspicuous; that better results might have been secured in Chicago by the construction of filtration works and that such methods would have proven much cheaper than the expensive sanitary channel now in use.

With a few more seasons of great rain and epidemics of typhoid in Chicago, directly attributed to the thorough flushing of sewage into the lake from regions that fail to drain into the canal it is likely to become impressed upon the community, and generally speaking the State, that, as we have stated before in these columns, a stupendous sanitary blunder has been made.

In searching for reasons for this mistake, a phase of the situation undiscussed by Jordan, it is at once apparent that the drainage system in operation and from which so much was expected was undertaken without the approval of eminent sanitarians, for even the casual inquiry by Jordan has disclosed facts and conditions which would have seriously jeopardized the undertaking or prevented it entirely, had competent authorities been consulted.

## Editorial Notes.

### NATIONAL MEDICAL DIRECTORIES.

Recently the Editor was asked by the publishers of one of the National Medical Directories to make suggestions for the betterment of their publication and the following correspondence resulted:

Springfield, Ill., Jan. 2, 1903.

Dear Sirs:—

Your favor of the 29th inst. "No. 2," at hand and I am very pleased to communicate with you upon the subject of your medical register and directory of the United States and Canada. I believe and trust there is a very great future for this publication if conducted along the right lines. I have always contended that it would be better for such a house as yours to issue these directories than for the professional organizations such as I represent. A great many of the officers of the local and state societies have agitated this matter of the issuance of directories by the societies and as far as I have been able I have always advised against it. I notice that this has been abandoned recently by the Chicago Medical Society. Just the reason for their not taking the matter up I am not advised, but I am glad they have decided not to undertake it.

Now for your directory to properly fulfill the needs of the profession I would suggest that greater care be taken in admitting names to the directory. In the first place I would suggest that you leave out of your directory of medical journals such fake publications as the \_\_\_\_\_ of Chicago, which is not probably a medical publication at all; also the \_\_\_\_\_ which has no certain existence and certainly does not represent scientific medicine in the least. There is also a journal in \_\_\_\_\_ that I object to your classing among scientific publications. It is entitled the \_\_\_\_\_; also one entitled \_\_\_\_\_ issued at \_\_\_\_\_. This is largely a personal advertising publication on the style of the Philistine and a very poor imitation of it. The \_\_\_\_\_ Journal issued \_\_\_\_\_, Chicago, is another journal that I would be very slow to admit to the list. This journal is fighting all efforts to raise the standard of medical education and progress. I have not been able to get hold of a copy of it lately, but it is probably still in existence.

Another questionable journal is entitled \_\_\_\_\_, issued from \_\_\_\_\_. I suspect some of the other journals in your list, but so far as I personally know those mentioned are the ones which are deserving of condemnation. Again referring to the list of medical colleges No. \_\_\_\_\_, I have looked up this college and have it from reliable practitioner at \_\_\_\_\_ that this is a diploma mill of the worse character. \_\_\_\_\_ issues his diplomas from \_\_\_\_\_. I suppose there are quite a number of others in the country. I mention only this one personally known to me.

In regard to the names of medical men throughout the country I would suggest that the greatest care be used in preventing the insertion of dentists and veterinarians as I have heard that a number of these gentlemen were included in your previous list. If it is possible for you to verify the credentials of every one of the names in the list and to leave out those names which you are not able to verify as genuine graduates of medical schools, I think the value of the Directory would be greatly enhanced. I believe that a great deal of the objection to the Directory as it now stands is that the honorable and criminal have the same standing on your pages. I would also like to see greater care used in crediting medical frauds with their alleged society connections. To be more specific, I will take the case of one Dr. B. This man states that he is fellow of the American Association of Physicians and Surgeons and a member of other societies, none of which actually exist. It is wrong it appears to me to allow this fellow to spread himself on the pages of a decent publication and proclaim untruths in this manner. I have had occasion to look up this fellow, and I suppose there are quite a number of others over the country who deserve similar condemnation. B. has quite an advertisement on page — of the last issue of the Directory which should not be admitted I believe. Also another advertisement which should not be admitted is the advertisement of one \_\_\_\_\_ of Chicago advertising the \_\_\_\_\_ which was found so disreputable when it burned down some months ago. It seems to me that with your wide connection over the country it would be easy enough to shut out fraudulent institutions and to secure better prices from those inserted of a reputable character. If I can help you in any way in making up a directory which will have the confidence and respect of the profession and make it an ally of the honorable practitioners I should be glad to do so. If you will send me proof sheets of Illinois I will be glad to go over them. I have also a pretty complete scrap book containing the advertisements of medical fakers in Illinois, which I would be glad to loan you. I believe your intention to enlarge the name space will be an improvement.

Yours very truly,  
....., Editor.

Jan. 14, 1903.

Dear Doctor:—

Your favor of the 2d inst. duly received and is greatly appreciated. It is just such criticisms as you have been kind enough to make that we want for our Register. If we do not see our way to adopt all of such suggestions, we undoubtedly will take advantage of some of them. A Medical Directory published for profit must be regarded from two standpoints; one from that of the physician and the other from that of manufacturers and dealers in preparations and instruments used or prescribed by the profession. We can see where it would be desirable to separate the names of non-graduates and illegal practitioners from



those who are regular and ethical, that is from a physician's standpoint. On the other hand, the manufacturer and dealer wants to sell his goods and is not so particular as to the professional character of the man through whose influence they are sold. He wants the names of all practitioners whether they are ethical or not and if he cannot buy such a Directory from us, he will do so from some one else and invite competition. It is not possible for two National Medical Directories to exist profitably. Where both are published, one must go to the wall sooner or later, for both will lose money. We shall be very glad to omit the names of non-medical publications from the list of Medical journals. What would you suggest as the best means of determining which are proper to insert in that list and which are not. Many in the list have never been seen by us.

Where we know that the college is fraudulent or not recognized by good medical authority, it is invariably stated. We had not previously received information as to the character of the ——— Medical College, and we are glad you have called our attention to it. We shall also be pleased to have a list of names of persons not members of medical societies who claim that they are. We have tried to be particular in this regard but as the society lists which we receive are not always reliable, we are never certain that some member's name may not have been omitted or that he may not have become a member after the list was made out. If we can have the assistance of the secretaries of societies to the extent that they will vouch for the correctness of their lists down to a certain date, we would then be safe in omitting mention of membership in such societies by persons claiming before that date to be members. We think you will see the point. We may receive a list this month which is correct at this time. Next month, a man whose name is not in the list may claim to be a member of the society and if that portion of the Directory where his name appears is then in press, we do not have time to investigate. Some such cases are unavoidable. We shall be pleased to have you send us your scrap book of the advertisements of the men you suggest as erroneously claiming such memberships.

Now as to the advertisements. We tried in our last edition to govern ourselves by the class of advertisements admitted into Medical Journals. There seems to be no rule for this. If you can give us any suggestions that will aid us in this direction, they will be thankfully received. We have assurances from all parts of the country that our work is being appreciated and we expect to continue publishing the Register. We want to make it an ethical publication. At least as nearly so as possible and greatly appreciate the co-operation of the representative men.

It seems to us that it is greatly to the advantage of the profession to have pretenders shown up and the only way to do it is to insert their names.

Thanking you sincerely for your valuable and pains-taking letter and hoping to hear

from you again soon on the lines herein suggested, we are,

Yours very truly

## Correspondence.

### DR. FOSTER MISREPRESENTED.

New Haven, Ill., Feb. 13, 1903.

*Editor Journal*—One James R. Allen, has sent several type-written letters to the postmaster at Emma, Ill., which purport to be a recommendation for me. These letters were written and mailed without my knowledge or consent and, in trying to do me a favor he has done me an injustice. I do not claim to cure cases that other Doctors fail to cure and I hope Mr. Allen, who purports to be a medicine drummer will not attempt to do such a thing again. I wish to denounce his action through the columns of your paper.

Yours very truly,

I. A. Foster.

## OBITUARY.

### Julius Kohl, M. D.

Dr. Julius Kohl was born in Grenzhause, Province of Nassau Germany, April 18, 1838, and in 1853, when fifteen years of age, emigrated with his parents to America and settled in Belleville, St. Clair County, Illinois. Not long after reaching Belleville young Kohl secured a position in a drug store that he kept till in 1856, when he entered the office of Dr. Trapp, and began the study of medicine. Later he matriculated at St. Louis Medical College, St. Louis, Mo., and in 1859 graduated from that institution.

Shortly after receiving his diploma Dr. Kohl located in Centralia, Ill., for the purpose of practicing his profession. June 16, 1860, Dr. Kohl, was united in marriage with Catherine, daughter of Dr. Berghoff, and in the same year removed to Columbia, Ill., where he industriously practiced his profession for six years.

In 1866 Dr. Kohl, feeling the need of a larger field, changed his location to Belleville, Ill., from whence he never removed. Dr. Kohl built up a large practice in Belleville that continued to the day of his death, thirty-six years after opening an office in that city. He had a wide reputation as a surgeon, was no mean operator, and patients came from far and wide to consult him.

When Governor Altgeld assumed the gubernatorial reins in 1893, Dr. Julius Kohl was ap-



pointed a member of the Illinois State Board of Health, and four years later when the state executiveship passed to Governor Tanner, Dr. Kohl was again made a member of the State Board of Health.

At the time of his death Dr. Kohl was the oldest alumnus of the St. Louis Hospital Association; he was an honored member and an ex-president of the St. Clair Medical Society; was a member of the Illinois State Medical Society and also of the American Medical Association, and for the last named organization prepared several most creditable papers.

As a citizen Dr. Kohl was exemplary in every particular. He was one of the founders of the First National Bank of Belleville, and for the first five years of its existence was its president. He was one of the organizers and moving spirits in the Good Government League of Belleville and at the time of his death was one of the directors of this association. Of him his associate members said: "Dr. Kohl was one of those clear-headed far-sighted, progressive, conscientious men, who never lost sight of his fellow-man. \* \* \* \* In his life the world may find an example of citizenship worthy of emulation; one which we hope will always bear commanding influence in the city and state in which he lived so long and was so well known. It may be justly said of him that he assiduously practiced a conscientious devotion to duty in all the stages and walks of life through which he passed."

During nearly the whole of 1902, Dr. Kohl mainly on account of an obstinate bladder trouble realized that his health was giving way and towards the end of the year he sought eminent medical council in St. Louis, but obtained only temporary relief. Returning home his trouble increased and finally on Sunday, January 4, 1903, death came to his relief.

The funeral occurred Wednesday, January 7th, from his residence, No. 119 Illinois street, Belleville, to St. Peter's Cathedral. The obsequies were very largely attended, the cathedral being filled with friends of the departed, and members of St. Peter's parish and congregation gathered to pay their last sad tribute of respect to the much admired and universally esteemed citizen and physician.

At the cathedral the services were deeply impressive, the Very Rt. Rev. Bishop John Janssen celebrating requiem high mass, assisted by Chancellor Hagen, and eight other priests of the diocese. Chancellor Hagen, in the course of the service, paid a just and eloquent tribute to the memory of Dr. Kohl as a citizen, a Catholic and a physician.

Following the impressive services at the cathedral the funeral cortege formed and wended its way to Green Mount cemetery, where all that was mortal of the lamented Dr. Kohl was consigned to Mother Earth.

The St. Clair County Medical Society held a special meeting on Tuesday afternoon, January 6th, to take action upon the death of Dr. Julius Kohl, when the following tribute to his life and character was offered:

"This Society is again called upon to mourn the loss of one of its most-respected members.

We meet today in special session to offer a tribute to the memory of Dr. Julius Kohl.

"Dr. Kohl was a representative man. He was not only an able physician and surgeon, but a ripe scholar, a man of business, a genial gentleman, active and honorable in every relation of life. He was twice president of this Society and for thirty-five years its secretary. He was a faithful and regular attendant upon its meetings, and did more to promote its interests than any other man. He had faith in the medical profession and sought its elevation. He looked upon organization as one of the best means for the attainment of this end. As president of this Society he labored hard to secure good attendance and active interest in its meetings. As its secretary he kept a faithful record, not only of its proceedings, but an outline of many of the papers read and cases reported. As a member of the State Board of Health he did much to elevate the standard of the medical profession in the State. As president of the Board of United States Pension Examiners he was skillful and conscientious in all his examinations and reports, and gave to the government the best of a skill and knowledge that had required the work of a lifetime to attain."

At the annual meeting of the Illinois State Board of Health held in Springfield, Jan. 13, 1903, the following action was taken relative to the death of Dr. Kohl:

"Whereas, Dr. Julius Kohl, formerly an honored member of the Illinois State Board of Health died at his home in Belleville, Ill., Jan. 4, 1903.

"Resolved, That we recognize the ability, integrity and manly courage that characterized the deceased, and the unswerving fidelity, honesty and fearlessness that animated him in the discharge of every duty while a member of the Illinois State Board of Health.

"Resolved, That we tender our sympathies to the family of the late Dr. Kohl, to his immediate friends and to the citizens of St. Clair County in the irreparable loss they have so recently sustained."

## State Items.

Consent of the patient, or of some person authorized to speak for him, must be obtained by a surgeon before he performs an operation, according to a decision handed down by Judge Murray F. Tuley, of Chicago. The outcome of the operation, the court held, is not to be considered. Without express consent, the judge finds, a violation or trespass on the body of the individual is committed by the surgeon in his use of the knife, and ground is thereby established for a damage suit.

The case involved in the finding was a suit brought for Mrs. Parmelia J. Davis against Edwin H. Pratt. In 1898 Dr. Pratt performed the operation of hysterectomy on Mrs. Davis in treating her for epilepsy. Mrs. Davis, it was

alleged, was then in an unsound mental condition, and has since been adjudged insane.

Her husband, E. N. Davis, who is a traveling salesman and who lives at Fernwood, testified that he had not given the physician permission to make the operation. Damages of \$3,000 were awarded.

"I am satisfied in this case," said Judge Tuley in his opinion, "that the preponderance of the evidence is the doctor did not have the consent of the plaintiff or of her husband to perform this operation. The doctor's evidence impresses the court with the feeling that a surgical operation of the character that was performed on the plaintiff was, to him at least, a trifling matter, and that he believed he had the right, if he thought the patient would be benefited by such an operation, to use his own judgment and act upon it without much regard as to what the patient or her friends might desire.

"The fact that neither the sister nor the husband was present when this operation was performed is a strong circumstance tending to show that the doctor acted without the consent of the husband. One or the other would naturally have been present at the hospital at such a time.

"It is not claimed that the doctor performed the operation in an unskillful manner; no malpractice is charged. The absence of malice does not excuse an unauthorized trespass on the body of the plaintiff."

Dr. Pratt said yesterday, as he had as a witness in court, that he had obtained the consent of Mr. Davis.

"He gave me carte blanche," the physician said, "to use my own discretion, except, of course, to do as little as possible. Two operations were made. It was hoped the first would suffice, and before it was undertaken Mr. Davis gave me this authority. I shall appeal the case."

Other surgeons when asked for opinions on the matter agreed that some proper consent was needed.

"The rule is," said Marshall D. Ewell, "that if the person under the physician's care is strong minded, his consent to the operation is necessary. Should the operation be performed without the consent of any one legal action for damages could be sustained."

"The patient should know what is to be done," Nicholas Senn said. "However, it may be hard to explain the case. Then the physician may find on examination, complications not expected, and which may necessitate an immediate use of the knife. Such exceptions tend to prevent the application of any hard and fast rule."

"As I understand medical practice," said John L. Porter, "the rule is to obtain the consent of the patient wherever practicable. One exception to this occurs when it has been previously agreed that the physician shall be guided solely by his own judgment and do what he considers best."

"If the patient had had epilepsy long," said H. V. Halbert, a specialist on nervous diseases, "I would not place much confidence in her testimony. It is always best for physicians to

obtain the consent of the patient. They generally seek it from the sick person or from relatives."

Dr. Jaques of the Chicago Health Department in a recent address before the Woman's Progressive Health Club attributed to filth the typhoid fever epidemic of last summer, and declared the department had been forewarned of its coming by the condition of the city water. He said the drainage canal was as yet accomplishing nothing.

Lakeside Hospital, Chicago, was recently fined \$25.00 and costs for violation of the city building ordinances.

The Alexian brothers' annual report of the work of their hospital at Belden and Racine avenues, Chicago, shows much charitable work has been done. In 1902, 2,981 patients were nursed in the hospital, 1,912 being dismissed as cured. Of the 305 who died 122 were taken to the hospital in a dying condition. Of all the patients treated 1,681 paid the fees, 397 paid according to their means, and 903 were nursed free. City ambulances took 693 accident victims to the institution.

According to religion profession 1,610 patients were Catholic, 1,172 Protestant, 54 Jewish, and 145 professed to no particular creed. Of the total number 1,764 were single men, 833 married, and 384 widowers.

The nationality of the patients varied greatly, 961 being Americans, 8 Armenians, 56 Austrians, 6 Belgians, 10 Bohemians, 43 Canadians, 3 Cubans, 41 Englishmen, 4 Frenchmen, 141 Greeks, 889 Germans, 6 Hollanders, 3 Hungarians, 293 Irishmen, 34 Italians, 151 Poles, 18 Russians, 225 Swedes and Norwegians, 13 Scotchmen, 2 Spaniards and 66 Swiss.

The Lake County Hospital association at Waukegan has been offered \$20,000 to erect a new building. The offer comes from Mrs. Jane McAllister, who has made many large gifts to charity.

The new building will be erected on the old lot as soon as possible. It is proposed also to have numerous beds endowed by various churches of Waukegan.

The Children's Hospital Society of Chicago held its first annual meeting in Fullerton hall, Art institute, Sunday February 15th, at 3 o'clock.

The objects of the society are to enlarge existing facilities for the care of sick and crippled children, to encourage scientific research, and to aid in the diffusion of knowledge concerning diseases of children. The society records show that less than 300 beds for children are now endowed in Chicago hospitals, and its aim will be to increase this number.

The Sisters of St. Francis, who have been in charge of St. Mary's hospital, East St. Louis, since 1883, were superseded Jan. 22, 1903, by the Sisters of Poor Handmaid of Fort Wayne, Ind. The change was made necessary, it is said, owing to a dispute that arose over a division of the funds of the institution. Bishop Janssen



of Belleville is said to be responsible for the change. The hospital was built by citizens on parish ground.

Concerted and scientific effort to stamp out tuberculosis began recently in Chicago when a conference of physicians, charity workers, and visiting nurses was held in the Unity building. A committee was named to consider methods and agree on a plan of campaign. When this is done a permanent organization will be formed.

One of the speakers was A. R. Reynolds, commissioner of health. "What the city government can do to prevent the spread of tuberculosis is only a small part of what should be done," he declared. "The solution of the problem lies in the education of the masses. Statistics show that the death rate from tuberculosis has gradually decreased in the last forty years in every civilized country in the world. This is the result of education."

G. W. Webster of the State Board of Health pledged the support of that organization.

"The people should be made to understand," said he, "that the spread of the disease may be checked by the following precautions: The destruction of the patient's sputum, good food, proper ventilation, abstinence from alcoholic liquors, and hygienic environment."

"I do not agree with Dr. Reynolds that there has been a real decrease in the death rate from tuberculosis," said W. A. Evans. "There has been a decrease in the death rate of all diseases, but the decrease in the tuberculosis rate has been less than for the other diseases."

The committee appointed consisted of the following: Mrs. James L. Houghteling, Mrs. Hugh J. McBurney, E. P. Bicknell, Dr. Alice Hamilton, Dr. W. A. Evans, and Dr. A. C. Klebs.

Recently a lady teacher in the Chicago Public Schools was found to be afflicted with pulmonary tuberculosis. The Board of Education promptly ordered a disinfection of the room in which she had been teaching and adopted the following resolution:

Resolved, That the superintendent of schools be and hereby is authorized temporarily to suspend from duty any teacher or principal who is reported to be afflicted with any disease which would either expose the pupils to the dangers of infection, or would have a tendency to retard progress of school work, or affect discipline, and that in doubtful cases, or whenever the superintendent deems it advisable, such persons be subjected to a free medical examination by two of the medical inspectors of the board of education. That such teachers or principals be reinstated to their positions according to the rules of the board upon presenting from one of the board's physicians a certificate vouching for their complete recovery."

Trustee Dudley and Dr. Hartung, Supt. Cooley, and Supt. of Compulsory Education Bodine, who has charge of the board's corps of medical examiners, were constituted a committee to formulate health rules to be applied to the teachers and principals.

The teacher in this instance was a Christian Scientist who with characteristic inconsistency said:

"No, sir, I am not sick, nor have I been, I am a Christian Scientist and I am taking treatment from a Christian Science physician. He assures me that I have no lung trouble or other disease. At the worst I may be troubled with catarrh."

Albert A. Ames of Minneapolis, Minn., sometime mayor of that municipality, who was recently arrested in New Hampshire as a fugitive from justice, is a graduate of Rush Medical College, 1862. He had been elected mayor of the city four times, was surgeon general of the State Militia, surgeon of the leading railroads and member of medical societies. As a result of his misfortunes he is said to be a physical wreck. He has been charged with accepting bribes and with other errors in his conduct of the office of mayor. In his fall from his high estate he doubtless deserves the sympathy of the profession which has heretofore honored him.

In December, 1901, we called attention to the numerous branches of the so-called British Medical Institute which had been established in this State and partially exposed the methods employed to swindle the public. The promoter of these enterprises was one W. H. Hale, who was located at Jackson, Mich., and, according to Polk's directory, was possessed of titles galore, one of them being president of the Polytechnic Society of Chicago, whatever that may be. That Hale was possessed of the same characteristics usually shown by the advertiser the following telegrams would seem to indicate:

Jackson, Mich., Jan. 26.—"Dr." W. H. Hale, head of the British Medical Institute of this city, with branches at Rochester, N. Y., and other cities, was arrested today by Officer William C. Muir of Rochester, N. Y., on a charge of forgery. It is alleged that Hale treated a Rochester man, took a savings bank book as security, and that Hale, or his Rochester partner, Stewart, obtained money in excess of lawful charges by forging orders against the savings bank pass book. Stewart was first charged with the forgery, and indicted by a grand jury. Hale is out on \$300 bonds, awaiting an application for requisition papers.

Jackson, Mich., Feb. 19.—"Dr." W. H. Hale, who was arrested in this city for alleged forgery committed in Rochester, N. Y., and whose extradition was honored today by Gov. Bliss, has fled the country, forfeiting his bail bonds. Tonight word was received from Detroit that he had been seen there making his way to Canada.

One E. E. Rohrabach, 65 Randolph street, Chicago, licensed by examination by State Board of Health in 1894, is traveling over the State making one-day stands and advertising himself, with photograph showing a masonic charm, as the world famous rupture specialist and Chicago's noted rupture specialist. In the Springfield Register the world famous states: I came here at the earnest request of a number of my patients living in this locality. Most of them first came to my office in Chicago for treatment, where I handle most of my cases, but the requests that I come out for one day were so numerous and urgent that I finally decided to make the trip. A very small portion



of my patients come to me from my newspaper advertising, etc., etc.

The Chicago Recorder announces that with the completion of the present volume it will cease its official relations with the Chicago Medical Society. The Recorder since its establishment in 1890 has furnished every member of the Society gratuitous copies. During the first years the Society made an annual appropriation for the benefit of the Journal. In recent years the profits received from a large line of advertisements has carried the expenses of the publishing and editing. Recently the burden of supplying nearly 1,500 copies of the Recorder monthly, without pay, has become unreasonably large and the Recorder welcomes the change which is to be made. The Recorder will be continued on broader lines, at liberty to receive the best material from whatever source and reject that of an inferior character.

George W. Webster of Chicago, the well-known professor of medicine in the Chicago Medical College, has been recently mulcted to the extent of \$13,000 in a suit for malpractice in the Circuit Court of Cook county. The plaintiff now 17 years of age, was treated by Dr. Webster eight years ago for disease of the knee-joint. The patient was a pauper and persistently removed the dressings applied by the medical attendant. The joint did badly and to save the child's life the limb was amputated above the knee. Negligence and incompetent management were charged. Strange to say the jury rendered a verdict for this enormous sum. A new trial has been prayed for and every member of the State Society will hope for a different verdict if granted.

### New Legislation.

The following bills of interest to the medical profession have been introduced by members of the General Assembly now in session:

By Senator Jandus—Allowing the relatives of an injured person and his or her guardian or legal representative to be admitted to the presence of any injured employe of a mercantile institution, store, etc., or to the building, room, or premises where such person or persons was injured.

By Chipfield—Providing for the infliction of the death penalty by electrocution. The bill follows the New York law and provides that the executions shall take place within the walls of a penitentiary, to be designated by the court, and shall be under the supervision of the warden. The prisoner is to be kept in solitary confinement after being delivered to the warden and shall see no one except the officers of the prison, his counsel, minister, physician, and members of his family. The warden shall invite to be present at the execution a judge of the Circuit court, the state's attorney, and sheriff of the county where the conviction was had, two physicians, and twelve witnesses. The criminal may designate two ministers to be present. In addition the only persons

present shall be seven deputy sheriffs or assistants to the warden. No religious services other than those held within the walls of the penitentiary shall be held over the dead body and it must be interred at once with quicklime.

By Speaker Miller—Repealing the act of the Forty-Second General Assembly requiring reports of births and deaths and regulating the interment or other disposal of dead bodies.

By Dr. J. A. Wheeler, of Sangamon, providing for a state colony of epileptics. It provided for the appointment of a commission of three members by the governor, who shall serve without remuneration. It also provides for an appropriation of \$350,000 to be used in building of the colony. The total appropriation asked is summarized as follows: Three hundred and twenty acres of land, \$100,000; twelve dormitories, provided with heat and light, \$123,000; kitchen, bakery and laundry, \$15,000; industrial building and brick plant, \$22,000; plumbing, sewerage, water supply and fire escapes, \$30,000; furniture, \$20,000; ordinary expense for maintenance of 300 patients during the year beginning July 1, 1904, \$40,000; total \$350,000.

By Mr. Geshkewich—Requiring all doctors, surgeons, and midwives to register their names and residences with the county recorders and also the course of practice they pursue; whether they are graduates of medical colleges, their experience, etc.

By Mr. Hardin—Appropriating \$200,000 for the establishment of a state sanitarium for consumptives.

By Senator Stubblefield—Giving osteopaths representation on State Board of Health.

By Senator Berry—Preventing the employment of special attorneys by state boards and commissions; also one giving the state commissioners of public charities absolute control of all the state charitable institutions, abolishing all the trustees, and giving their duties to the commissioners of public charity, who are to receive a salary of \$1,200 per annum.

By Mr. Backus—Amending the child labor law so as to require that the age of a minor employe shall be made the subject of an affidavit from a dentist as to the age of the child, determined by the dentition.

By Mr. Backus—Creating a state board of barber commissioners, consisting of five barbers appointed by the governor at a salary of \$5 per day for each day of service, and a secretary at \$1,500 per annum. The board is given general supervision of the barber business, and in the main its provisions are along the general lines of those of the boards of health and pharmacy. Ten men are to be employed as inspectors of barber shops at a salary of \$75 a month and traveling expenses of 5 cents a mile.

By Davies—To govern the employment of minors in the state. The bill is a composite measure, bearing the indorsement of Edgar T. Davies, state inspector of factories and work shops; Chicago Federation of Labor; compulsory department of the Chicago board of education, and numerous child saving organiza-

tions. A slight educational test must be applied to children between the ages of 14 and 16 years before they are to be permitted to work. Minors under the age of 16 years shall not be permitted to work between the hours of 10 P. M. and 6 A. M., thus doing away with night work for children. The bill prohibits the employment of minors under the age of 16 years at extra hazardous and dangerous occupations and defines the character of such hazardous tasks.

By Mr. Chipfield—Appropriating \$60,000 as the initial step for a new state institution, where children of less than 14 years of age suffering from deformities are to be treated.

In the senate Mr. Parker introduced the civil service bill recommended by the board of county commissioners of Cook county. The bill places all the county elective officers of Cook county under civil service. Also one making it unlawful for any person to sell or give away any patent or proprietary medicine, offered or advertised for curative purposes, unless the bottle or package containing the same shall plainly disclose the ingredients of the preparation or compound.

Senator Stubblefield introduced a bill giving the State Board of Health power and authority to adopt rules and regulations for the examining and licensing of trained nurses.

By Mr. Hinds—Creating board of control of three, elective by people, to have charge of state charitable institutions.

By Mr. Mundy—To prohibit the marriage of whites to persons having one-eighth or more of negro blood and providing a penalty for persons who solemnize such illegal marriages.

By Mr. Wilkerson—Providing for the appointment of an osteopath as a member of the State Board of Health and to regulate the licensing of osteopathy.

Senator Putnam's bill—Changing the name of the asylum for the incurable insane to the Bartonville State Asylum, and authorizing the trustees of state institutions to sell 160 acres of land which is unfit for farm purposes and devote the proceeds to the purchase of productive land.

Senator Parker introduced into the senate two reform resolutions. One authorizes the state officers and those in charge of state property to draw, charts, maps and plans of the state institutions which are to be returned to the secretary of state and state auditor for the benefit of the committee of the general assembly. They are to be filed in these two offices and the work is to be done under the supervision of the state architect.

The second resolution refers to the state pay roll. It orders the heads of all state departments, state institutions and boards to prepare a full and correct list of their employes, which shall be sworn to as to its accuracy.

By Mr. McManaman—To regulate the surrender and placing in homes of dependent children.

## Local Societies.

The Physician's Club meeting that occurred on Monday, Jan. 26, 1903, was a "Ladies' Night," and the program was so largely one of mere entertainments that a report of it for publication in the Journal would be hardly possible. The following preamble and resolutions in regard to Child Labor were read and unanimously adopted, and perhaps deserve being reported.

"The employment of children in breadwinning occupations and their detention from school is inimical to the hygienic as well as to the moral welfare of the community. The effectiveness of our statutes designed to regulate and control child labor is therefore a matter of especial interest to the medical profession. Be it therefore,

Resolved: That the Physician's Club of Chicago, representing 250 physicians of Chicago, and vicinity, commends most heartily the efforts inaugurated by the Industrial Committee of the Illinois Federation of Women's clubs, to secure such amendment of the existing statute in reference to child labor as will make it effective.

Resolved: That the members of this club will use their influence collectively and individually, to secure the passage of bill number —.

Resolved: That a copy of these resolutions be sent by the secretary, to the Chairman of the Industrial Committee of the State Federation of Women's clubs and to the Chairman of the Committee to which bill number — shall be referred and that they be printed in the regular notice for the next meeting of the Physician's Club."

L. H. Mettler, Official Reporter.

The Chicago Neurological Society held a regular meeting Jan. 22, 1903, with Vice-President H. H. Donaldson in the chair.

## STRUCTURE OF NEUROGLIA TISSUE.

By G. Carl Huber, Junior Professor of Anatomy and Director of the Histological Laboratory, University of Michigan.

The paper reported on observations extending over a series of years, embracing a study of the neuroglia tissue of different classes of vertebrates, made especially with the Benda's sulphalizarate toluidin blue method. The research was undertaken with a view of harmonizing the various views expressed concerning the structure of neuroglia tissue, and of obtaining data which must of necessity be at hand in order that experimental work involving structural changes in the neuroglia tissue might be undertaken. The report embraced observations made on the neuroglia tissue of man, dog, cat and rabbit among the mammals; dove, tortoise and frog; in all of which the neuroglia tissue of the white matter of the spinal cord was especially considered, since it was found that the relation of the structural elements of this tissue might here be more



clearly made out and its relation to other structures more exactly defined. The results obtained were controlled by observations on the grey matter of the cord and brain.

The following general conclusions were reached: The neuroglia tissue of all vertebrates consists of neuroglia cells and neuroglia fibres. The cellular elements vary greatly in size and shape, denending in the main, on the spaces which they occupy. In the majority of the neuroglia cells a granular cytoplasm can be clearly made out. This varies greatly in amount, at times forming only a narrow zone around the nucleus; again present in much larger quantity and presenting very distinct protoplasmic branches. In certain cells, which are designated as "free nuclei," no distinct cytoplasmic covering can be seen. The nuclei of neuroglia cells vary in size, shape and structure. The majority of them may be spoken of as vesicular nuclei with chromatin in the form of a number of relatively large granules, variously disposed. Other nuclei, usually the smaller and smallest seen, present the appearance of compact masses of chromatin, taking the stain relatively deeply. Transition forms between the two varieties of nuclei specially mentioned may readily be made out. The neuroglia fibres show very definite relation to the neuroglia cells, being imbedded in the peripheral layer of their protoplasm. With the method used, whenever the preparation is properly differentiated, the neuroglia fibres could be traced through the protoplasm of neuroglia cells without interruption. In imperfectly differentiated preparations, they often appeared as processes. The small, deeply stained "free nuclei" and the free nuclei showing a viscular structure, show no definite relation to neuroglia fibres, and are looked upon as undifferentiated and undeveloped neuroglia cells.

Microscopic preparations substantiating the statements made were demonstrated.

#### ON THE MESOBLASTIC ORIGIN OF THE NEUROGLIA TISSUE.

By Shinkishi Hatai, from the Neurological Laboratory of the University of Chicago.

On examining the cross sections of the central nervous system of the white rat and mouse, two kinds of nuclei, differently characterized, are easily recognized. One kind coincides in structure with that found in the nerve cells, while the other resembles very much in size shape and staining character, and in an internal structure, the nuclei found in the walls of the capillaries. These nuclei, so-called, are always surrounded by a small amount of cytoplasm. These facts led the writer to a systematic study of these structures in order to determine their origin within the central nervous system.

For the investigation, new-born white rats and mice were used. The tissues were fixed in Carnoy's mixture and the paraffin sections were made and stained with toluidin blue and erythrosin.

One group of the nuclei, which resembles in structure as well as in shape, those of the nerve

cells, can be identified without difficulty as derived from the ectoblast. For convenience, I called these nuclei, Type I. The identification of the other group of the nuclei or Type II, is, however, difficult, since these nuclei have no similarity to the nuclei of the ectodermal derivatives. On examining the capillary wall, I noticed very frequently a nucleus projecting outwards, and in some cases, these nuclei were isolated from the capillary wall, but lay close to it. Between these two appearances, various intermediate stages could be easily found. In some cases, a tip of the nucleus is still attached to the capillary wall while the rest of it has become separated. This appearance shows very plainly the migration of the nucleus from the capillary wall into the surrounding tissue. There is no danger of confusing these nuclei with those of the leucocytes which escape from the capillary wall and exhibit amoeboid movements, since they differ from them both in structure and size: the former being very much larger than the latter. As soon as the nuclei are separated from the capillary wall they migrate away from the capillary.

The following observation is in favor of the above conclusion. A large number of the mitotic figures, in various phases, are often visible in the nuclei of the capillary wall. In such a locality where the mitoses are abundant, the nuclei are so closely placed that in some cases, the one nucleus overlaps the others, the outermost nucleus protecting outwardly, thus showing the first step of the migration.

From the above, there is, I think, no doubt that the nuclei which I have called Type II, have been derived from the capillary wall and migrated away from it. The identification of these nuclei, which have migrated from the capillary wall, with neuroglia nuclei, is difficult. Since it has been shown that a small amount of connective tissue is present in the central nervous system in both young and old animals, this connective tissue might have been formed by the nuclei which I am describing, but there is no evidence to support the view that this could occur. The large number of the nuclei which have migrated from the capillary walls suggests at once that some of the neuroglia tissue is supplied by these nuclei. This idea is favored by the fact that similar neuroglia nuclei to those migrated from the capillary wall or mesodermal in type, exist in the adult animal.

According to the investigation of Kuhne and Chittenden, the neuroglia fibre is produced by the chemical transformation of cytoplasm into neurokeratin. Chevalier further showed that the same chemical substance exists also in the medullary sheath of the peripheral system. The presence of the neurokeratin meshwork in the peripheral nerve has been shown by histologists also. If it is true that the entire medullary sheath in the peripheral system is formed exclusively by the mesoblastic cells, one can assume that there is here a chemical transformation of mesoblastic cytoplasm into structures characteristic of ectodermal cells. This evidence favors my hypothesis that the nuclei which have migrated from the capillary wall might be transformed into the neuroglia tissue



and give rise to neurokeratin. Since we have no evidence that Weigert and Benda's technique brings out the neuroglia fibres of ectodermal origin only, these methods can hardly touch the point mentioned above. I therefore conclude at the present moment, that the nuclei which migrate from the capillary wall into the central nervous system are one source of the neuroglia tissue. The reasons for this conclusion may be summarized as follows:

(1) The great number of these nuclei; (2) neurokeratin may be formed not only by the cytoplasm of the ectodermal cells, but also by the cytoplasm in mesodermal cells; (3), presence of the nuclei of mesodermal type in the central nervous system of the adult animal; (4), ordinary connective tissue nuclei present in the central nervous system are there in much smaller numbers than the nuclei which have migrated from the capillary walls; (5), there is no evidence that the neuroglia fibres stained by the modern neuroglia techniques are of ectodermal origin only; (6), since the cytoplasm undergoes very easily morphological and structural alterations while the nucleus is more resistant, it follows that the nuclei are the better indication of the genetic relationship of the cells; (7), Capobianco and Fragnito, who observed the nuclei which migrate from the meninges into the central nervous system and believe these nuclei form a part of the neuroglia tissue, were able to trace the successive transformations of the former to the latter.

This observation of Capobianco was made on the spinal cord of *Mus decumanus*.

#### Chicago Larynological and Climatological Association.

The annual meeting was held in the rooms of the Chicago Medical Society, Jan. 26, 1903, with President Moreau R. Brown, in the chair.

The following officers were elected for 1903: President, Norval H. Pierce; Secretary and Treasurer, John Edwin Rhodes; Members of the Council, Moreau R. Brown, J. T. Campbell, and F. Menge.

The following is an extract from the annual report of the Secretary: Our hearts are saddened tonight by the loss of our beloved fellow, Edward T. Dickerman. The first one called by death, from our membership; a man of winsome and charming personality, an indefatigable worker and a student; a brilliant operator, a man successful from every point of view, in his chosen profession. Cut down in a day, by the grim destroyer. We mourn his loss, we revere his memory, and rejoice that in his short life, he had done so much to bring honor to his profession."

Otto T. Freer presented a paper entitled "Palliative Operation for Laryngeal Carcinoma; and Perichondritis of the External Nose."

History: The patient's age is 49. His family record and past history present nothing of note. His present trouble began three years ago when he commenced to notice an annoying desire to clear his throat. A physician at this time told him that he had inflammation of the throat and treated him locally for a month. Six months after the beginning of his trouble swallowing of fluids and food began to lead to

fits of coughing so that he was induced to consult a specialist who told him that he had a nonmalignant tumor and removed some pieces with forceps. Difficulty in swallowing and the coughing caused by it were his chief symptoms until October, 1902, when he became troubled with gradually increasing dyspnoea. This led him to go to the Chicago Polyclinic in December, where Dr. Dickerman removed some large pieces of a tumor with the snare, giving him a good deal of relief. The symptom of pain has been entirely absent excepting such soreness as followed operations, and the breath has not been offensive.

Inspection of his throat showed a large, firm non-ulcerated tumor which filled up the entire space between the epiglottis and the posterior pharyngeal wall so that the only portions of the larynx visible were the rim of the epiglottis, a small part of the right arytaenoepiglottic fold and the fossa pyriformis upon the right side. The tumor invaded the left lateral wall of the pharynx, broadly distending the pharyngo-epiglottic fold, and was evidently attached to the posterior wall of the pharynx, as a probe could not be passed behind it. There was but moderate obstruction to respiration but the growth acted as a damper to the sounds coming from the larynx so that the patient's voice was clear but lacked all reasonance and sounded as if distant. He could not pronounce the vowel sound ah. Swallowing evidently was only possible past the right side of the larynx and it was hard to understand how food could get past the tumor at all.

As the patient begged for relief I removed in two operations as much of the tumor as I could by means of a large Heryng double epiglottis curette. The operations were very tedious as the curette, though very sharp would often refuse to cut through the tough growth, so that a fresh hold had to be taken. The result was a removal of the anterior part of the neoplasm so that the laryngeal interior with the perfectly intact vocal cords became visible and the voice natural. The posterior half of the growth could not be taken away because of its firmness and I hope to destroy it later by electrolysis. Hemorrhage from the operations was trifling and there was no inflammatory reaction to speak of. The voice and respiration were made normal and swallowing was decidedly improved.

Several hard lymphatic glands may be felt in the left carotid region and the appearance of the deeply infiltrating growth is unquestionably that of a carcinoma, which has progressed far beyond the hope of radical removal. The question concerning the propriety of palliative operations in cases of malignant tumors of the larynx is I think to be answered in the affirmative provided they be favorably situated for the giving of some relief and provided the tumor be of a structure that will make dangerous bleeding improbable. The more superficial portions of a carcinoma are but little likely to be well supplied with vessels so that it is reasonably safe to operate upon it provided its base be not too deeply entered and the cutting away be strictly confined to tumor tissue. Sarcoma, however may be of the angiomatous

variety and bleed by continuous free oozing which can not be checked if the growth be deeply entered, as was my experience with one of these growths which I severed in opening the larynx from in front. I have also seen a vascular carcinoma bleed furiously when cut into in the same way and a case is on record of death from hemorrhage due to ablation of a carcinoma of the cord by the natural passages. In the softer growths removal of large portions may be attended by some risk of dangerous hemorrhage but considering the deplorable state of the patients this risk is justifiable.

In the present case ulceration has followed the operation and healing seems to be taking place more rapidly than in normal tissue.

A usual feature presented by this patient's history is non-recognition of the disease by his physician at a time when radical operation was probably possible. The absence of pain, ulceration and fetor are not uncommon features of carcinoma of the larynx even in advanced cases.

Histological examination shows the neoplasm to be an epithelioma of the squamous celled type. The surface of the piece from which the sections were made is covered with normal epithelium which rests in orderly arrangement upon a basement membrane, the basal layer of cells having its long axis at right angles to this. The epithelium of the cell nests of the carcinoma in distinction to this may be seen to crowd into the surrounding connective tissue in a disorderly manner, there being no distinct basal layer or basement membrane. This difference is beautifully shown and is one of the most important points in the histological distinction of carcinoma from simple epithelial proliferation with descent of pegs into the subepithelial connective tissue in which a regular basal layer of cells may always be demonstrated.

History of the second case: The patient's age is 41. He has always been in good health until the year 1890, when he states that he began to have obstruction in the right nostril which he attributed to catarrh. In 1894 he had what he describes as cartilage sawed away from the septum in the right naris. This relieved the patient's nasal obstruction, but since the operation he has been troubled with the formation of scabs in the anterior part of the nose. In removing these he discovered that he had a perforation of the septum. His habit is to blow the scabs from his nose or remove them with his fingernails and he even uses the head of a nail to get them away, as they interfere with his breathing. Last October the external nose became sore as the scabs in addition to clinging to their old location within the nostrils adhered to the ala nasi. In November the right ala nasi began to be drawn in and in December the external nose became much swollen and sorer than it is now. There has never been a purulent or foul discharge from the nose and the affection causes no pain.

Examination shows the heart, lungs, larynx, pharynx and nasopharynx with the posterior nares to be healthy. The lymphatic glands are normal and the man is in robust health. In-

spection of the anterior nares shows the right ala nasi to be drawn in by a cicatrix which nearly closes the nostril and which occupies the site of the alar cartilage which is absent. Below the nasal bones the external nose is swollen but the skin is of normal appearance. Palpation shows the bony skeleton of the external nose to be unchanged but the region of the triangular cartilages to be a good deal thickened. Anterior rhinoscopy is difficult because of the infiltrated and stiff left ala nasi and the cicatricial narrowing of the right nostril. A large perforation of the cartilaginous septum may be seen which has for the most part smooth, healed edges with occasional patches that have the appearance of epithelial denudation rather than of ulceration, in other words look raw. The outer walls of the nasal fossae and the septum back of the perforation have a normal appearance. Tilting back the head the mucosa behind the left triangular cartilage of the external nose is seen to be in a greatly thickened condition and a probe can be passed up into a fistulous opening between the cartilage and the skin of the external nose, to the depth of  $\frac{3}{4}$  of an inch. An eroded surface follows the edge of the right nostril but distinct ulceration is nowhere visible, nor are granulations or sequestra of bone or cartilage to be found. The patient has improved under treatment by local applications of lanoline to soften the crusts. He has also been given potassium iodide fifteen grains three times daily. There has been no marked change in the local appearances as the result of treatment.

The differential diagnosis of perforating ulceration of the septum is of well-known difficulty and the perichondritis of the cartilages of the external nose in this case adds to this.

Tertiary syphilitic disease may create perforations limited to the cartilaginous part of the septum, and is prone to attack the cartilages of the external nose and may have led to loss of the right alar cartilage in this case by ulceration or by gummatous perichondritis leading to atrophy and softening of the cartilage. The long course of the affection, however, since the year 1894, would make it probable that by this time the disease, if syphilitic would have extended to the bony frame-work of the nose and have led to syphilitic ozaena with necrosis and sinking in of the nasal bridge. There is no ulceration visible that indicates an advancing syphilitic process nor anything that has the appearance of gummy infiltration. The absence of syphilitic lesions in the throat or elsewhere and of a syphilitic history speak against the presence of the disease.

Tubercular ulceration of the septum could hardly have lasted so many years without other localizations than the nose and would manifest itself by tubercular tumor forms, or infiltrations or ulcerations. Nothing characteristic of these processes is visible, what raw surfaces are present looking like denuded rather than ulcerated.

Idiopathic perforating ulcer of the septum is of insidious advance and often the only symptom is the formation of scabs which stop the nostrils while slow molecular destruction of



the cartilage due to chronic perichondritis gradually creates perforations which may become very large.

In this case probably the disease was started by a traumatic perforation which on account of the patient's habit of picking crusts from the nose was continually irritated and infected and slowly extended during the lapse of years. When the mild septic perichondritic process so generated reached far enough forward it extended to the triangular cartilages. It is also probable that the alar cartilage was exposed to septic perichondritis by the rough treatment to which the patient has subjected his nose during the long time mentioned, and that in this way it became slowly softened and absorbed as there is no history of its being cast off by suppuration. The softening of the triangular cartilages may in the end lead to their disappearance and to cicatricial retraction of the entire cartilaginous nose, without the appearance of external ulceration.

Though I regard the morbid process in the cartilages of the external nose in this case as one analogous to that leading to idiopathic perforation of the cartilaginous septum, that is chronic perichondritis, I admit that syphilis cannot as yet be positively excluded from the diagnosis. The hard infiltrations of leprosy and rhinoscleroma are quite unlike the appearances presented by this patient.

**J. Holinger:** The second case described by Dr. Freer, while difficult of diagnosis, is an affection that has been described as tuberculosis of the anterior part of the nose. I can show Dr. Freer a case which resembles this one as closely as one egg looks like another. The points in the two cases are very pronounced. The general condition of the patient is very good, although the affection is an extremely chronic one. I have been treating the patient since 1898, and I made the diagnosis at the first consultation and made my prognosis accordingly. He was at the hospital several times for the removal of infiltrations and granulations and repeatedly it looked as though a complete recovery was assured. Although I instructed the patient to come to my office about two months after his apparent recovery, and found new foci of the disease. While the disease is rare, it has been described accurately somewhere, I believe in the *Archiv für Laryngologie*. It is a local tuberculosis, and remains so. In no case, to my knowledge, has general infection followed. The absence of fever does not speak against the diagnosis, because the affection is a localized one, and does not progress.

The disease is interesting from the standpoint of the etiology. It is a tubercular infection par excellence which is produced by direct inoculation, and the habit of the patient in removing the crusts with the finger-nails tends to corroborate the statement.

The disease usually begins with the formation or appearance of small white spots at the septum, where crusts always occur and recur. These crusts removed in the same characteristic way with the finger-nail. I saw a patient who manifested this characteristic. There was a white superficial spot (scar) be-

side which I could actually see a small tubercle which, however, did not last long. It disappeared, and the scar became larger. After this I did not see a pronounced tubercle again, still the scar persisted, and scars persisted for a long time. Finally the white scar was replaced by normal mucous membrane. The treatment in these cases consists in removing whatever infiltration can be reached, and then the rest is destroyed with ointment. This ointment, if applied for a day or two, or for several days in succession. It will produce a clean, ulcerating surface, which by and by is covered with zinc salve. There is no question as to the diagnosis in this case, in my mind.

**William L. Ballenger:** From the casual observation I have made of this case, and from the description given by Dr. Freer, I should say it was probably one of tuberculosis of the nose. The long duration of the disease, with its non-progressive character, is characteristic of the tubercular process in this part of the anatomy. I recall a case that was under my observation for three or four years, and which was likewise under the observation of Max Thorner, of Cincinnati, Ohio, for six or seven years before it came to me. In this case there was apparently no extension of the disease during that time. In the summertime the ulcerated patch would almost entirely be covered over, but would re-appear each succeeding winter. There was no separation of the septum. The case was interesting and illustrated the non-progressiveness of the disease in this locality.

Dr. Holinger spoke of the scar which was left after the disappearance of the tubercle in his case. I am not sure what he means, because ordinarily tuberculosis does not leave a scar, thereby distinguishing it from syphilis in the larynx. Tuberculosis of the larynx is not so likely to produce stenosis, for the reason that it does not lead to the formation of a large amount of scar tissue. I take it that in this case there is not an excessive amount of scar tissue. The scar tissue present may have resulted from the operative procedures, as well as from the disease itself.

**John Edwin Rhodes:** Notwithstanding the dissenting voices that have been heard in reference to the diagnosis of the case reported by Dr. Freer, and acknowledging all that Dr. Holinger has said, in reference to tuberculosis of the nose as true, still, it seems to me, there is an element of doubt, from the fact that the traumatism was excessive, as anyone, who examined the finger-nails of this man and saw the manner in which he removed the scabs from the nose, could see. An infection might come from these finger-nails, although they seem to be in a very good condition tonight. When we saw the case before, they were not clean, and I believe infection could come from that source. The excessive traumatism caused by the action of the finger-nails and their uncleanly condition would, to my mind, leave some doubt as to this being tubercular in character. I think Dr. Freer brought these points out very clearly, and I am inclined to agree with him as to the etiology in this case.



With reference to the case of carcinoma of the larynx, Dr. Freer has asked for the ideas of the Fellows with reference to the removal of these growths. The number of operations that have already been done on the larynx of this patient, at brief intervals, shows that the reproduction of the growth has been rapid. I have at present under observation in my service at the Cook County Hospital a case of carcinoma of the right tonsil and soft palate, and of the posterior portion of the alveolar process, in which this proliferation of tissue after operation can be seen beautifully, and it seems to grow, like a mushroom, in a night. Its growth has been much more rapid since pieces of it have been removed. I do not believe it is good practice to remove these growths operatively from the larynx. I should favor a tracheotomy at once. Just how much can be accomplished in treating such cases by the X-Ray, I do not know. I believe there are no cases on record at the present time of cures of carcinoma of the larynx, by the X-Ray, although it is possible carcinoma of the larynx might be reached and treated efficiently in this way. One case I read of recently of the soft palate was treated by thorough cauterization and removal of the tissues by this means and then exposing them to the X-Ray. By this method, it is said that the growth had entirely disappeared and had not recurred. It is not good practice for us to temporize by endolaryngeal methods, but to do tracheotomy first, allowing the patient to die breathing well at any rate. Of course, if pain is excessive, the use of the X-Ray should relieve that feature of the disease.

**Frederick Menge:** I would like to ask Dr. Freer what stain was used in the preparation of these sections.

**Dr. Freer:** Dr. Holinger's positive diagnosis of typical tuberculosis in my case of disease of the nasal cartilages seems to me a hasty one. Tuberculosis seems to me in this case to be an unlikely possibility and not a certainly existing condition. It is not proper to assert the existence of tuberculosis positively in any case unless the assertion be sustained by the histologic proof of the existence of bacilli and tubercular tissue. The condition presented by this man's nose is too rare to be typical of so common a disease as tuberculosis. It has puzzled a number of us that have seen it. All that is to be found is thickening of the cartilages of the external nose, a large perforation of the septum and the loss of one alar cartilage, the whole being lined with a cicatricial mucosa without any ulceration and without the presence anywhere of tissue which is characteristic of any special morbid process. Cicatricial deformity of the external nose may result from so many conditions, especially syphilis and vary so much in shape that I do not see how it can be regarded as typical of anything and I do not think that in tuberculosis the cicatrizing process, if it result, will always take a form that is unvarying enough to form a type.

A presumptive, not a positive diagnosis of tuberculosis might be made in this case if it were possible to see evidences of the granuloma, the characteristic tissue of tuberculosis any-

where, but there are no tubercular tumors, granulations or infiltrations to be seen nor are tubercular ulcerations, with their peculiar gnawed out edges, and fringe of little miliary ulcers and miliary tubercles visible. Though the latter are seldom visible the little ulcers coalescing to form larger ones are usually so. All that is apparent in this case is scar tissue and that might be due to many things that have preceded it. I think therefore that it is hasty on the part of Dr. Holinger and Ballenger to positively declare my case to be tuberculosis of the external nose without histologic proof of the condition. I should have furnished this if I had seen any tissue characteristic of an active pathologic condition anywhere to remove. I am pleased that Dr. Menge should praise the sections of tumor presented. The stain used was hematoxylin, and the sections were fixed in paraffin.

In reply to Dr. Rhodes I wish to say that in my experience the symptoms which give the patients most distress in large carcinomata of the upper larynx are dyspnoea and difficulty in swallowing. The former may be relieved by tracheotomy but the dysphagia must be relieved, if possible by removal of as much of the obstructing growth as can be taken away even at some risk to the patient. This will enable him to swallow fairly well for some time until the tumor again fills up the pharynx when it may be trimmed down again. In this case there has been no inflammation or ulceration after the operations and the return of the excised part of the tumor is hardly perceptible.

As far as the use of the X-Ray is concerned I recall a case of a very large adeno-carcinoma of the interior and upper part of the larynx with a great tumor behind and under the lower jaw due to lymphatic involvement which was treated for weeks daily with the Roentgen rays with decided irritation of the skin without any check being placed upon the growth of the tumor. It may be that, simple squamous celled carcinoma such as exists in the case presented, will respond better to this treatment, but the deep seat of laryngeal carcinoma makes it impossible to let the rays strike its surface directly and as it can only be reached through the skin and laryngeal cartilages from without it is not well suited for treatment with the X-Ray.

**J. Holinger:** I would like to say a word or two more in reply to the remarks of Dr. Freer. He stated that he thought it was rather rash for Dr. Ballenger or myself to make a diagnosis of tuberculosis of the nose in this case without a histologic examination. The anterior part of the nose cannot be considered as part of a cavity lined with mucous membrane, but with epidermis, and consequently we must expect that a disease of this part of the nose is more similar to those of the epidermis and not of the mucous membrane. Tuberculosis here looks more like lupus than other forms of tuberculosis. The whole clinical picture of the disease is so accurate and distinct, that there is hardly any mistake possible.

The clinical picture is more important than the pathologic. It is a well-known fact that in lupus we hardly ever find characteristic

tissue changes, and especially we never find tubercle bacilli. That is the reason why we were in doubt so long as to whether lupus was really to be classed among tuberculous diseases.

**Dr. Rhodes:** I should like to have Dr. Hollinger furnish the reference he mentions before the proceedings are published.

**Dr. Freer** (closing the discussion): We all know that lupus is a benign form of tuberculosis but clinically the two diseases take quite a different course, ordinary tubercular ulceration being much more rapid and destructive than lupus, but characteristic of lupus is the lupus tubercle which infiltrates the corium as a macule or appears above it as a nodule or merges into infiltrations or granulations or breaks down into ulcers. It often ends in cicatrization but about the cicatrix and in it fresh lupus tubercles are visible. In this case the retracting scar has reached the skin of the external nose and drawn in its wing, yet with such abundant opportunity to appear externally upon the face if lupus nodules were present none are to be seen, the skin of the external nose remaining white and smooth, with none of the characteristic crusts ulcers or red infiltrations of lupus.

I have seen cutaneous tuberculosis, it is an active process characterized by verrucous infiltrations, granulations and ulceration. That does not exist here.

It is my intention to remove a piece of the very unpromising mucosa from the diseased area in this man's nose and report the histologic findings at the next meeting.

#### **Erythema and Superficial Ulceration of the Soft Palate, Probably Tubercular in Origin.**

**William L. Ballenger:** I intended to present a young lady, sixteen years of age, but as she has since entirely recovered from the pathological lesions, the exhibition of her would be of no particular interest. However, her case is interesting to me, because of my inability to readily arrive at a correct diagnosis. The family history is negative. Her brothers and sisters are healthy; her father and mother are living, both past fifty years of age, and in good health. There is no history of tuberculosis or syphilis in the family. The girl has been examined carefully, and no evidence of syphilis was found anywhere.

Six months ago she had swelling of the glands of the neck on either side. These were noticeable particularly in the posterior triangle of the neck, and she thought wise to consult a physician. On examining the throat, he found an eruption. There were reddened areas and whitish plaques at certain places. Her mother states that about six months ago she, in examining the throat of her daughter, found a white membrane about half an inch in diameter located in the fauces. When I saw the case first, there were thin, whitish pellicles of membrane corresponding to the erythematous patches shown in the drawing. The next day there was not a vestige of this whitish pellicle of membrane to be found. The erythematous patches were present, on either side of the soft palate, meeting in the median line above the uvula. There were fissures extending in a zig-zag-like tract in the same area, these being

of a grayish color. Upon close examination, this was found to be a simple breaking-down of the epithelium in this area. At the edge of the soft palate, adjacent to the uvula, on either side, there were broadened areas of this epithelial break-down. Upon the right anterior pillar there was a slightly whitish veil of membrane, which could be lifted up from its outer border. A little later in the history of the case an oval-shaped pellicle of membrane formed just above the uvula on the soft palate, and in its center was a gray line showing where the epithelium had broken down. At still another period in the history of the case a whitish pellicle of membrane formed upon the left anterior pillar.

The question arose in my mind as to the diagnosis, for upon it would largely depend the treatment. I thought of secondary syphilis, because of the superficial ulceration and of the symmetrical distribution of the eruption. The two sides were very much alike; there being a little more eruption upon the right than upon the left side, but it was almost the typical, geometrical eruption that is described by various writers and is so beautifully pictured in Lennox Browne's text-book. Then I considered the question of the tubercular origin of the eruption. In order to be clear as to this portion of the history, I had the patient examined by Charles Spencer Williamson, who made a report to me, which I will not take the time to read, in which he stated that the apex of the left lung was fixed, or had become adherent from a previous tubercular inflammation. The right lung was freely movable. He gave her the tuberculin test, and found a rise in temperature of  $2.9^{\circ}$ . He pronounced her a tuberculous subject. His opinion almost led me to the conclusion that the eruption was tubercular; still it did not have the characteristics of a tubercular process. There were no miliary tubercles, and none of the usual signs, except in very few particulars, of it being tubercular in character. I then swung back to my diagnosis of syphilis, and could not understand very well how the secondary manifestations of syphilis could last for six months without any more changes taking place than were found here. Dr. Williamson reported that the glands in the region of the neck were enlarged, also the axillary glands were slightly enlarged. Below this there was no enlargement of the glands.

Several laryngologists in Chicago examined the case, none of whom was willing to venture a diagnosis. A Cincinnati and Indianapolis laryngologist also examined the case, with like results. When Dr. Levy, of Denver, was in the city during holiday week, I invited him to look at the case. I value his opinion, because he has had a large experience in examining throats of tubercular patients. He said there could be no doubt as to the patient being tubercular, although the eruption had was not tubercular. He stated that he had seen a number of cases of erythematous eruptions, with superficial ulceration limited to the epithelium, in whom there was simply an impoverished condition of the blood from whatever cause. A simple anemia might produce it. This impoverishment



of the blood, due to tuberculosis, might be produced by any other dyscrasia. In this case we had a simple erythema, with a breaking-down of the epithelium within a certain area, but the eruption itself was not characteristic of any particular disease. He advised me to let treatment severely alone, so far as the local conditions were concerned. He told me that if the patient were allowed to go out freely in the open air, and take cod liver oil, the eruption would disappear. I should have stated that the patient had a uniform temperature of approximately one degree above normal. I saw the case, for the first time, on the 6th of December. In secondary syphilis we have a temperature which is irregular in type. In tubercular lesions of the pharynx and fauces the temperature is more nearly uniform, as in this case. I mention this symptom because it might mislead one in arriving at a diagnosis where the symptoms seem to be vague or indefinite.

My object in presenting the case was simply to show that the eruption was exceedingly simple, due to an impoverishment of the blood, and I may say that one might be easily misled in diagnosis on account of the undoubted tubercular condition of the patient.

**Dr. Rhodes:** What was the result?

**Dr. Ballenger:** It is now approximately three weeks since Dr. Levy saw the case, and the patient has been taking fresh air and cod liver oil, as directed, there are no visible signs of any lesion. The temperature has declined to normal. The temperature for two or three weeks was almost universally at 98.2°, up to December 29th, when it rose for two or three days, then went down again. I saw the case day after day, and no two days did the eruption present anything like the same appearance. It was simply marvelous to notice the rapidity with which the condition changed.

The Chicago Medical Society held a regular meeting January 28, 1903, with President Wm. A. Evans, in the chair.

**Prostatectomy, its Indications and Technique,** by G. Frank Lydston, Chicago.

The author states that in order that prostatic surgery should be placed on a firm basis, several conditions should be complied with.

1. There should be a selection of cases in which a broad dividing line is drawn between those in which serious complications exist, and those in which they are absent. An operation performed even in patients of advanced years, in whom sepsis and renal disease have not developed, is comparatively safe. Prostatectomy compares very favorably with many operations which are considered less formidable, always providing it is performed at an early period in the development of the prostatic overgrowth. An operation upon the prostate in the presence of normal urine is, at least in the case of the perineal method, less formidable than many operations for stone, and when cases are properly selected the statistics of the surgery of the prostate should be of some value, and the various radical operations will be shown to compare very favorably, as regards mortality, with other fields of operative work. In the

collection of statistics, a broad dividing line should be drawn between the cases in which catheter life has not been established and the bladder and kidneys are sound, and those operated after a more or less prolonged period of catheterization has elapsed and secondary, bladder and renal changes have occurred. The former class is that upon which the statistics of the future will be based.

2. Both the profession at large and the laity should be impressed with certain fundamental facts regarding the prostate: (a) The inevitable progress of prostatic overgrowth when once it has commenced, in by far the majority of cases. The cases in which symptoms do not develop, and the patient consequently remains perfectly comfortable throughout his entire life, do not necessarily establish non-progression of prostatic overgrowth, but simply prove that some patients are exceptionally fortunate in that the mechanical conditions produced by it do not obstruct the urinary way. (b) The results of catheter life, during which infection almost inevitably occurs. The longevity of patients after the habitual use of the catheter has been once begun is, on the average, about five years, and those five years, in the majority of cases, hardly worth the living—in many instances by no means worth the living. (c) That an early operation, performed before the onset of bladder and renal complications, warrants a favorable prognosis, in by far the majority of cases.

3. The wisdom of an early diagnosis, to be followed by radical operation, if the progress of the prostatic overgrowth is not speedily checked, is sufficiently obvious. The fatalism underlying the catheter habit, and the idea that all old men are doomed naturally to urinary disturbance, should be relegated to the valley of dead lumber. Both physician and layman should be taught the advisability of careful supervision of the urinary apparatus of men at or above middle age. When symptoms are elicited, a careful examination should be made, and if enlargement of the prostate is found to exist, or develops later, the radical operation should be advised. There should be no compromise on the foregoing point, if mankind is ever to be freed from the misery produced by prostatic hypertrophy. The sooner the fallacious notion that all old men are legitimately entitled to misery during their declining years is exploded, the better for the profession, and, obviously, the better for the public at large.

After referring to the indications for operations in general for prostatic hypertrophy, the author stated that in several instances he has succeeded in draining the bladder and maintaining a permanent fistula by dissecting through the perineum a narrow tract, traversing the prostatico-rectal tissue, and entering the trigone. There is some difficulty in keeping a fistula of this kind open, but where the patient can be under observation, it is worthy of trial. The cases in which he has performed it thus far have not been very tractable, and he is unable to make any positive statement regarding its true value. So far as drainage of the *bas fond* is concerned, the method should be ideal, always



providing permanent drainage is shown to be practicable. The operation is not practicable in large prostatic tumors. That the fistula is not so easily controlled by mechanical means as one in the suprapubic region is self-evident, yet his experience thus far has been fairly satisfactory in this respect. In many cases the suprapubic or the combined suprapubic and perineal sections are necessary.

The modified, i. e., perineal, Bottini has its limitations, and, in his opinion, they are very narrow. However modified, the Bottini method is, in his opinion, a compromise with prostatic pathology and surgery, excepting in certain selected cases.

After speaking of the preparation of the patient, the author says that when the patient is placed upon the table for operation, the surgeon should understand that the correct method of operating will be governed largely by the character of the tumors. It is well to advise the patient before operating of the possible necessity of operating suprapubically.

The exigencies of the case may, in exceptional instances, be indicated by the preliminary use of the cystoscope. While this instrument adds to the accuracy of diagnosis, its use simply enhances the dangers of subsequent radical operations through the shock, traumatism and sepsis incidental to the exploration. In many cases of prostatic disease, in which a radical operation is absolutely necessary, the chief danger to the patient is from shock, acting reflexly upon the kidneys, to which is added the further danger of anesthesia. The patient should be prepared with a view to doing, not only perineal prostatectomy, but suprapubic section, if necessary. Shaving and antiseptics should be scrupulously carried out. Chloroform should be the anesthetic of election. The patient being placed in the lithotomy position, a medium-sized sound is introduced into the bladder and given into the hand of the assistant. An inverted Y-shaped incision is made in the perineum, the longer arm of the Y corresponding with the median raphe of the perineum, and the short arms traversing the region just in front of the anus. It is sometimes advantageous to make the lower incision curvilinear instead of Y-shaped. The length of the lower arms of the incision, or of the crescent, as the case may be, should be modified by the conformation of the perineum, which should be longer as the perineum is shorter, deeper and more fatty. The triangular flaps involved in the incisions should embrace all the tissues down to the muscular structure of the urethra. The triangular flaps, having been dissected up cleanly, so as to expose the outlines of the urethra clearly, should be everted and fastened to either buttock by a single strand of medium-sized silk traversing its free angle. Careful blunt dissection downwards along the urethra to the apex of the prostate must now be made, the rectum and the tissues in the ischio-rectal fossa being pulled down strongly by a retractor in the hands of an assistant. If sufficient room cannot be obtained in this way, it can be increased greatly by resecting the coccyx. As the dissection is being made, the assistant, using

the sound as a lever, its convexity being directed perineumwards, pries the prostate down into the wound as much as possible. Where the prostatic tumors are of moderate size and quite circumscribed, it is sometimes possible to enucleate them without opening the urethra. It is sometimes advisable to do this, unless the condition of the bladder be such as to positively demand drainage or intravesical work. Even here a retained catheter may be better than a perineal drain. Where a single prostatic tumor exists on one or the other side, an attempt should be made to enucleate it without opening the urethra, unless there be some positive indication for the latter procedure. A free incision in the capsule of the prostate is rarely necessary. The author finds that the best plan is to make a puncture with a pair of strong scissors. The puncture is enlarged by opening the blades of the scissors; the dilating finger of the operator does the rest. In some instances an incision of this kind should be made upon either side. Where opening the urethra seems advisable or unavoidable, the prostatic retractor shown by the author will be found exceedingly useful. An opening is made upon the staff at the apex of the prostate. Through this incision the prostatic urethra and neck of the bladder are thoroughly dilated with the finger so far as may be. The prostatic retractor is now inserted closed, and under the guidance of the index finger in the bladder opened in such a manner that its convexity rests upon the lower segment of the bladder. The sound is, of course, removed before the neck of the bladder is dilated, and the retractor inserted. An intelligent assistant has now command of the situation. The slim wire shank of the instrument, while it is a guide, in a certain sense, to the enucleating finger, does not encroach by its bulk upon the field of operation. In some cases it is found impossible to pass a rigid staff into the bladder. Under such circumstances, one of two procedures may be resorted to: (1) A gum elastic catheter may be passed as a guide; (2) the urethra may be opened in the apex of the prostate upon a staff which can be readily passed down to this point. In enucleating the prostatic overgrowth, it should be remembered that in some instances damage may be done by over-zealousness in the attempt to remove all the adventitious tissue. No circumscribed overgrowth should be spared, but it should be understood that there is more or less diffuse tissue hyperplasia surrounding the tumors proper, and secondary to them, which it is both dangerous and unnecessary to remove, as it shrinks down readily when once the offending tissue has been extirpated. All distinct intumescences should be removed. Where enucleation is not practicable, *morcellement* with cutting forceps is required.

In cases in which distinctly circumscribed single or multiple tumors are not found, but where there is diffuse enlargement of one or both lobes, it is usually practicable to extirpate the entire mass by intracapsular enucleation. If a distinctly pedunculated or even plainly circumscribed median tumor exists, it

may not be practicable to remove it extravasically. Under such circumstances, it should be twisted off within the bladder, or enucleated through an incision upon its mucous surface.

He desired to emphasize the fact that in any instance in which the tumors are removed by incisions from the mucous side, either through the urethra or bladder, the ideal perineal operation is distinctly debarrad, and the operation reduced to the same plane, essentially, as that occupied by suprapubic cystotomy and intravesical extirpation of the prostatic overgrowths. Where the tumors are more or less polypoid in character, or, if sessile, are situated very high up, their bulk being distinctly intravesical, it is occasionally necessary to combine suprapubic cystotomy with the perineal method, and remove the tumors under consideration from above.

**Alexander Hugh Ferguson**, in the discussion, reported briefly 28 cases of prostatic hypertrophy upon which he had operated, with but one death. He stated that his first perineal prostatectomy was performed on the 20th of June, 1900. He practiced the suprapubic operation soon after its advocacy and recommendation by Belfield and McGill, but later discarded it for the perineal route.

**A. I. Bouffler** emphasized the importance of early operation in cases of prostatic hypertrophy. Early operation, he said, is safe, easy, and yields remarkably good results. In operating on these cases he prefers the so-called semilunar or Zuckerkandl incision, which exposes the base of the bladder and affords him ample room through which to work. He thinks the operative procedure should vary with the individual case.

**Joseph B. DeLee** read a paper on **Utero-Vaginal Tamponade; its Obstetric Uses**.

The author stated that the use of tampons inserted into the vagina for the control of hemorrhage is very old, and credit belongs to Dührssen for introducing and forcing on the medical profession the truth of the value of the utero-vaginal tamponade in post-partum hemorrhage. There are other uses for tamponade, which the author takes up in order.

The frequency of severe hemorrhage post-partum is variously estimated. In Germany Dührssen finds about three hundred deaths from it each year. The essayist has had no death from post-partum hemorrhage, but knows the details of two cases occurring in this city.

The causes of post-partum hemorrhage are atony of the uterus, lacerations in the parturient canal, and disordered blood.

Of primary importance in the treatment of any case of post-partum hemorrhage is the recognition of the cause. In cases of hemorrhage from atony, the routine treatment of the essayist is (1) brisk uterine massage; (2) ergot; (3) a short, but hot (125° to 130° F.), uterine douche; (4) bimanual compression of the uterus in anteflexion; (5) utero-vaginal tamponade.

There are other methods which the writer occasionally practices, e. g., compression of the aorta, drawing down the cervix with volsella, packing the vagina and bimanual compression

of the uterus through the tampon, external massage over the bald fist in the uterus, electricity, etc.

The tamponade in the writer's hands has proven so simple and so safe, that he uses it prophylactically, in cases where the bleeding is not great. After an operative delivery, where, often the patient has been in labor for many hours, and it is desirable to get her off the table and warm in bed as soon as possible, it is a very grateful procedure to remove the placenta quickly, and, if a little oozing persists, or the uterus shows a tendency to fill with clots, to tampon the whole tract. The patient then may be safely put to bed. Hemorrhage sometimes comes from the lower uterine segment, especially in cases of low placental insertion; again, from small lacerations here, that cannot be reached by suture. The tampon is indicated in these cases. After Cesarean section, it may be necessary to tampon the uterus because of atony. Where the appearance of the blood suggests some abnormality of its constituents, and where one tamponade has proven inefficient, the utero-vaginal tract should be repacked with gauze saturated with a ten per cent. solution of gelatine. In two instances of the writer's, this procedure stopped at once obstinate hemorrhage.

The technique of tamponing the utero-vaginal tract was described at length.

The reasons for the success of the gauze in stopping hemorrhage were set forth as:

1. The rough packing stimulates the uterus to contract. One can feel the uterus contract as its cavity is filled by the gauze.
2. The gauze tampons directly the site of the hemorrhage, and the pressure mechanically stops the flow of blood.
3. The gauze acts like a Mikulicz, and favors the clotting of the blood in its meshes and in the subjacent mucous membrane.
4. The gauze fills up the empty uterus. It is a clinical fact that in some cases the uterus will not close down on itself sufficiently to obliterate its cavity and stop the hemorrhage. A blood clot does not stop hemorrhage well, but gauze does.
5. The gauze lifts up and supports the uterus, relieving it of the congestion it undergoes when sagging in the pelvis. The re-establishment of an easy circulation does much to stop the hemorrhage.

The objections to tamponade were expatiated upon by the author, after which he mentioned fifty cases in which he was able to arrest hemorrhage by the tampon. In three of these it was necessary to remove one tampon and insert another. One of these, a uterine tear, was inefficiently packed by an excited operator, who was unprepared for the emergency. In two others, the patients were bleeders. In the first, the hemorrhage ceased gradually; in the second, it stopped definitely when the parturient canal was packed with gelatine gauze. The patient in whose case the tampon did not stop the bleeding was a hemophilic, with detachment of the placenta.



Numerous obstetric authorities were mentioned as recommending the use of the utero-vaginal tampon in post-partum hemorrhage.

As to the use of tamponade in placenta previa, the author finds little use for this measure.

The vaginal tampon is a standard and useful treatment of certain conditions occurring in abortion, but the writer recommends a procedure that is not generally practiced for the treatment of incomplete abortions, and for the induction of abortion for therapeutic purposes. When part of the ovum is expelled and it is impossible or undesirable to forcibly dilate the uterus and remove the remainder, a safe course is to pack the uterine cavity with a thin strip of gauze, then tampon the vagina tightly with sterile cotton and leave the case till next day. The cervix will then be found soft and easily dilatable, if not fully dilated, and the gauze with uterine contents expelled on top of the cotton tampon.

In inducing therapeutic abortion, the sac may be punctured, the amniotic cavity packed with gauze, and then the vagina. This may be done without anesthesia, and on the next day the cervix will be found softened, or even fully opened, so that the removal of the uterine contents is an easy matter. Abortion performed thus, in two sittings, is much less likely to leave injuries in the cervix, and where haste is not necessary, the method is to be preferred.

The utero-vaginal tamponade as a means of carrying medication to the parturient tract is employed by some accoucheurs. The essayist believes this field of usefulness is very restricted, and that the procedure is capable of much harm.

**Rudolph W. Holmes** practices utero-vaginal tamponade in cases of hemorrhage, and believes in its early use, stating that the best effect of the tampon is lost when temporizing measures have been practiced, and when the tampon is used as a last resort. He uses 6 per cent chinosol gauze, which is unattended with any unpleasant odor, when the gauze is removed at the end of twenty-four or forty-eight hours.

**A. Belcham Keyes** deprecated the use of the tampon by the general practitioner, saying that while its use is necessary and can be used to great advantage by experienced obstetricians, he did not think its use was safe when employed by the average general practitioner. He thinks there is a tendency on the part of the average practitioner to use the curette too freely in ordinary abortions, and as a result infection occurs. Cases were related in point.

**Dr. DeLee**, in closing the discussion, disagreed with Dr. Keyes that the utero-vaginal tampon should not be entrusted to the general practitioner, particularly practitioners who were familiar with the rules of asepsis.

Baur, Emil F., 1488 Milwaukee, ave.  
Beaumont, John F., 809-103 State st.  
Brown, J. S., 32 S. Hoyne ave.  
Chapman, George L., 902 Wilson ave.  
Clay C. M., 2687 Wayne ave.  
Calloway, W. L., 1400 Reliance Bldg.

Conner, Elspeth M., 102 W. Congress st.  
Everett, Henry H., 210 Reliance Bldg.  
Garen, D. H., 6300 S. Halsted st.  
Geiger, A. H., 110 Clybourn ave.  
Gould, Henrietta, 266 S. Lincoln st.  
Goldsmith, Alex. A., 3749 Vincennes ave.  
Graham, James F., 278 Bissell st.  
Herriman, W. D., 460 E. 63d st.  
Klovstad, A., 684 N. California ave.  
Raycroft, Joseph E., 6109 Greenwood ave.  
Reese, J., 6300 S. Halsted st.  
Reynolds, Ernest A., 553 W. 63d st.  
Rice, May Cushman, 6955 Perry ave.  
Rossiter, F. M., 614 Church st.  
Rowan, Charles J., 372 W. Adams st.  
McGuire, J. W., 75th and Greenwood ave.  
Merke, E. J., Bush Temple of Music.  
Montezuma, Carlos, 100 State st.  
Moore, Emma M., 6025 Prairie ave.  
Piper, Charles N., 6859 S. Halsted st.  
Pritzker, Louis J., 418 W. Division st.  
Schmidt, Marie S., 1601 W. 22d st.  
Schroeder, A. G., Polyclinic Hospital.  
Simmerman, Harris E., 1072 Lincoln ave.  
Sonnenschien, Robert, 571 W. Madison st.  
Stillians, Arthur W., 65 Randolph st.  
Stol, Sabastian, 564 S. Halsted st.  
Thome, Wm. McKee, 276 E. Superior st.  
Train, J. A., 683 Noble st.  
Wall, C. Delamere, 171 Blue Island ave.  
Wardle, H. W., 1074 N. California ave.  
Vaugh, William F., 1492 E. Ravenswood Park.  
Wean, Charles A., 2575 Magnolia ave.  
Weichbrodt, Ernest, 229 E. Division st.  
Wild, Theo., 465 Milwaukee ave.

The Chicago Medical Society has devoted three meetings in February to the consideration of the Report of the Committee on Constitution. At the meeting of Feb. 25th the committee made a final report which was adopted by the Society. The complete report will appear in the next issue of the Journal.

The Stock Yards Branch held a regular meeting at 4205 S. Halsted street, Thursday evening, February 19th. J. T. Sullivan in the chair. Forty were in attendance. Excellent papers were read by Drs. Riebel, Alibro and Gaebler. The President of the Chicago Medical Society spoke on the subject of organization.

**North Branch Medical Society.** A regular meeting of the North Branch of the Chicago Medical Society was held at the Chicago Academy of Sciences, on Feb. 12, 1903, H. G. Anthony presiding.

The program for the evening was a symposium on "Puerperal Infection," opened by R. W. Holmes. The discussion was continued by Drs. Rachiel Yarros, Buford, Kunz, Miller, Wagner, Reed and Churchill.

The Evanston Branch met in the Woman's Club rooms, Evanston Y. M. C. A., Thursday evening, Feb. 26, 1903, at 8:30 P. M.

W. S. Christopher read a paper on "Care of Children Through Puberty." Discussion opened by S. V. Balderston.

#### Announcement of Medicolegal Committee.

The Medicolegal Committee has employed Messrs. Pam, Calhoun and Glennon to act as counsel for the Society, and they are now prepared to advise with members in reference to



cases which have been started since Jan. 1, 1903. The committee decided to limit its work to this period, as cases that are now pending against physicians are in various stages of litigation. For the most part, attorneys have been employed, and it would be impractical to take up the old cases. The committee especially requests that the earliest possible notification of impending litigation be sent to the committee, together with all the facts available. Even threats, or if a member suspects that an action may be brought, it would be wisely brought to the attention of the Committee.

We would especially urge upon the members to take no action in actual or threatened proceedings until they have consulted with the committee. While we have thought it necessary to begin our work Jan. 1, 1903, the Committee is ready to advise with and assist any who may be involved in pending litigation. Legal services will only be rendered to those whose membership fees are paid in advance, as a certain proportion of the fund so paid in is set apart to meet the expenses of litigation.

The Adams County Medical Society held a regular monthly meeting in Quincy at the Conservatory of Music, February 9th, 1903, with President Gilliland in the chair.

The following members were present: L. B. Ashton, H. P. Beirne, J. N. Black, G. W. Burch, R. J. Christie, Jr., Jos. Fletcher, W. E. Gilliland, J. M. Grimes, H. M. Harrison, T. B. Knox, A. M. Liesen, E. B. Montgomery, H. J. Nichols, L. H. A. Nickerson, C. W. Pfeiffer, Jos. Robbins, Sarah Vasen, J. G. Williams and John A. Koch.

L. H. A. Nickerson, Chairman of the Committee on Public Health and Legislation, presented copies of letters sent to the various members of the legislative assembly at Springfield from our district and urged them to use their influence in securing the adoption of the new medical practice act. A favorable reply was received from Hon. Jacob Groves. The others written to did not reply. Dr. Nickerson urged that each individual member should speak or write to the representatives regarding the new act.

During the past month the secretary received the charter from the State Society, the same will be framed and according to the constitution will be in the custody of the secretary.

The applications of A. J. Enlow of Liberty and J. H. Pitman of Camp Point were received.

Virgil McDavitt of Quincy was elected to membership.

J. N. Black of Clayton gave a clinical report on "a case of contused and lacerated wounds of foot with luxation of ankle joint and treatment."

William Pevehouse, age 21, family history good, well developed and in perfect health.

March 18th, 1899, in attempting to board a moving train missed, his footing and was rolled between station platform and locomotive, left foot being crushed by wheel of tender, literally twisting and grinding central third of member into pulp. We called Dr. Garner, to assist in the event of primary amputation or the use of anaesthetic was found necessary. After the

usual precautions of rendering hands and instruments aseptic we made an examination and found contusion size of silver dollar over external surface of leg opposite center of shaft of fibula, involving tissues down to periosteum. Luxation of the ankle joint, foot being turned inward to a right angle, exposing articulating surface of tibia and fibula with astragalus. Joint ligaments and tissues being torn completely except posteriorly and internally, thereby not wounding posterior tibial vessels and nerves. We had to irrigate with considerable force (bi-chloride) 1-2000 to remove cinders and dirt, as he had taken a few steps placing exposed joint to ground with more or less weight upon it the shoe and sock being so torn as to afford no protection. Also external malleolus fractured. As near as we could ascertain, entire osseous structures were more or less crushed, broken or dislocated from the astragalo-scapoid and ocalcicuboid articulations forward to about anterior third of shaft of five metatarsals. The soft tissues of dorsal surface suffered proportionately. The most complete chaos was at the central third of the foot. There the solution of continuity was so extensive; effecting soft as well as osseous tissues, crushing and dislocating the latter, that the foot was broken and dropped like a worthless mass. This part being described approximately by a line drawn through the center of the fifth metatarsal across foot to the scaphoid articulation with three cuneiform, and involving the cuboid severing the tendons of the tibialis-anticus. Injuring external fibers of annular ligament, integument and superficial facia severing the tendons of the extensor-brevi digitorum also destroying the external saphenous vein and nerves, tarsal and metatarsal branches of dorsalis pedis artery. The injury to inter-osseous muscles and some ecchymosis to third muscular layer constituted all the damage to the plantar surface, thereby not interfering with the internal and external plantar vessels and nerves and their ramifications. The arch of the foot was destroyed, producing a convex instead of a concave plantar surface, the toes excepting flesh wounds escaped injury. Owing to the nature of injury there was but little hemorrhage or pain.

During all this examination and subsequent dressing patient was calm, composed and his suffering conspicuously absent, consequently no occasion for anesthetic.

Owing to mangled condition of wounds and destruction of so much vascular supply as well as limited opportunity for collateral circulation, we concluded all things considered, primary amputation the best thing to do for future usefulness, but at this stage of the game the patient rebelled and said foot would remain until he was ready to give undertaker a job, then we might amputate. He said he would take all risk in the case, for me to do the best I could and he would be satisfied. We removed some loose spiculae of bone, trimmed off with scissors all shreddy tissues advisable, molded parts back best we could, having first reduced luxation of ankle joint, irrigated entire foot with warm solution bi-chloride mercuri 1-2000, then used

powder, eight parts iodoform and two parts boracic acid.

The integument of the plantar surface being in good condition enabled me to apply a broad adhesive strip, bringing it up and attaching to upright especially provided thereby giving support and extension to limbered part of foot, using as a dressing iodoform and sublimate gauze ten per cent, former 1-2000 latter with roller loosely applied, immobilized by placing foot in fracture box for twenty-four hours.

From the condition of tissues injury was caused no doubt, by a crushing twisting force from external to internal surface transversely, body being rolled and doubled up as observed by eye witnesses.

About ten hours after accident respiration became very much accelerated with pain in precordial region, so gave sp. amm. aromatic 2 dr. every hour until dyspnoea was overcome, with mustard to chest, also three grains of dovers every two hours to procure rest at night. Eight next morning pulse ninety and regular, temperature  $99\frac{1}{2}$ , respiration 25. Ten thirty A. M. some pain so gave one grain crude opium and dressed foot at eleven, now leaving off fracture box, supplanting it by supports against inner and outer aspect of foot. At four P. M. found pulse 100 and regular, temperature 101 and respiration 25 with restlessness headache and some pain in foot, all of which I attributed to reaction from shock. I gave one grain crude opium every two hours until pain and restlessness was subdued, then broken doses of Sedlitz powder every hour until I obtained alvine evacuations, thereby lowering arterial tension. Gave Horlick's malted milk and light diet. I placed pads under leg from immediately below popliteal triangle to ankle joint removing pressure from heel, as it having been somewhat bruised I expected sloughing there.

To favor sloughing in the worst part of the injured member I kept on a greater quantity of gauze, keeping it quite moist with warm water, using over that a rubber protective, and while adopting these local measures I also kept up my opium to control pain when necessary. By the sixth day I removed a large amount of sloughed tissues with scissors and dressing forceps, also a good portion of the cuneiform bones, anterior third of cuboid and slivers from base of metatarsal leaving a ragged ugly looking hole, with nothing on dorsal surface for support and collateral circulation. The odor emitting from the foot at this stage was bad indeed and I was fearful of absorption and septic poison as a result. However, I scrubbed from the knee down with a stiff brush and castile soap, then gave it a most thorough curetting, using Volkman's sharp spoon and Hebra's bone scoop, then irrigated this time increasing bichloride to 1-1000, used powder blower to be sure of getting iodoform and boracic acid to remote septic regions then packing thoroughly every sinus with ten per cent. iodoform gauze surrounding all with bichloride gauze and roller rather snugly applied. In a few days of similar treatment I had a bright, clean healthy wound, no bad odor, neither depression nor elevation of temperature. Pulse,

temperature and respiration had been normal after the third day. Now I reduced strength of bichloride back to 1-2000 and kept up tight packing with gauze to establish strong granulations and insure healing from the bottom. In dressing foot the utmost caution was exercised to disturb ankle joint as little as possible, placing patient on his back and keeping foot steady as was commensurate with the means at hand, i. e., adhesive strips and lateral supports. After fourteen more days dressings and an occasional removal of spiculae of bone brings us to April 7th, I now placed patient on his side for rest as ankle joint was secure, lateral wounds being filled and firm with healthy granulations.

From second to fifteenth day dressing caused more or less pain, especially when curetting, but patient stood it without a whimper, taking nothing to overcome it excepting opium or dovers powders the first few days. I now began passive motion to ankle joint to prevent ankylosis. By the twentieth day (April the 7th,) the granulating surfaces of broken part of foot were ready for coaptation, and after a thorough cleansing, packing, and dressing, using pressure again plantar surface to help mold arch back placing all parts in that position most favorable for future usefulness, immobilized and left it decidedly alone for forty-eight hours by which time I had enough adhesion of granular tissue to give quite a considerable natural support, consequently I dispensed with all artificial means.

About April 15th, began dressing foot about every forty-eight hours, patient sitting upright in chair good portion of day and by the twentieth was taken in a buggy for daily rides, fresh air and sunshine. May tenth by use of crutches he would hitch his horse alone and ride about at will.

May 30th, two pieces of bone were exfoliated from shaft of second metatarsal. June 24th there was no evidence of irritation from necrosed bone and wound was all healed except opening about the size of small bean and about one-fourth inch deep opposite internal surface of base of metatarsal of great toe, he could place some weight upon foot and convexity of arch was a thing of the past. I used mechanical means to concave plantar surface to as near its original shape as possible, it being almost flat where arch should be and although quite a while since injury it seemed to be yielding to pressure daily and without pain or much soreness. The foot is one inch short and rather thick through dorsal-plantar and internal to external surfaces. Ankle joint motion is good, never swelled a particle when he went about on crutches. Power of toe extension is absent owing to sloughing of tendons of extensor-proprius pollicis and extensor-longus-digitorum. The anterior tibial vessels and nerves were also obliterated. Considering the mutilated condition of the foot the destruction of vascular and nerve supply, injury of bone, dislocation and fracture, I feel gratified with the results obtained.

I attribute my success in this case to the fact that I always kept foot and everything



used in or about it as nearly aseptic as possible, healing everything by open "Lister Method" stitching nothing securing perfect drainage, using for that purpose ten per cent. iodoform gauze and only on one occasion did I use carbolated rubber drainage. In using gauze I packed every sinus tight from bottom to surface and fluffy bunch on top.

By this method cell proliferation was rapid enough but firm and possessing wonderful power to resist disease, there being very little pus formation during reparative process, as to future arch elasticity we could not reasonably expect much. I can truthfully say at this writing you can scarcely notice a limp in his walking.

Discussion by R. J. Christie, Jr., Jos. Robbins, E. B. Montgomery, J. M. Grimes and W. E. Gilliland.

R. J. Christie, Jr., reported a case of gunshot wound with injury to the popliteal artery. Within ten days the wound had healed. An aneurism resulted and ligation of femoral artery was made in Hunter's canal according to the technic of Dawbarn. Gangrene set in which necessitated amputation. Recovery.

Discussion by E. B. Montgomery, Jos. Robbins and J. N. Black. Adjournment.

John A. Koch, Official Reporter.

The Sangamon County Medical Society met in regular session Monday evening in the circuit court room at 8:30 o'clock, B. B. Griffith, vice-president, in the chair, with sixteen members in attendance. The minutes of the last regular and the special meeting in regard to Dr. Shutt's death, were read and approved.

Upon motion of G. N. Kreider, a committee of three was appointed, by the vice-president, to change our by-laws to conform with that of the State Society as suggested by the president in his circular letter which was read. The committee appointed was G. N. Kreider, L. C. Taylor and O. B. Babcock; they were instructed to report at the next meeting.

The communication from Frank P. Norbury was read in which he desired to publish the original papers together with the discussions of our society, in the Medical Fortnightly, for which each member of the Society would have the journal mailed to him for one year at a cost of 25 cents. This communication was laid on the table.

Bills of Brown & Canfield, for wreath \$10; Phillips Bros., 100 programs \$1.50; secretary for stamps and janitor \$2.00, were read and ordered paid after they had been O. K'd by the board of directors.

The communication from Mr. and Mrs. Shutt and son, was read and ordered placed on file.

After the following resolution had been read, it was ordered spread on the minutes and a copy be sent to the family.

Whereas, Death having again invaded our presence and removed from among us our colleague Dr. Margaret Taylor Shutt.

Resolved, That we her fellow members of the Sangamon County Medical Society of which she was an active, interested and valued member for several years, and vice-president

for one year, do hereby record our expression of deep sorrow and affliction at this untimely loss. She possessed a noble, true and ambitious individuality, always striving for the highest ideals in her profession. Her interest in the unfortunate sick and studying for methods whereby to alleviate their condition was paramount. While her untimely demise leaves a gloom of sorrow over all she has left a record well worthy of emulation by all who had the pleasure of her acquaintance and association. She was a true physician.

Resolved, That the sympathy and condolence of this Society be extended to the father, mother and brother of the deceased in their sad bereavement and loss, and that the secretary be instructed to forward a copy of these resolutions to the family.

B. B. Griffith,

A. D. Taylor,

G. N. Kreider.

Fred S. O'Hara read an interesting and instructive paper on Poisons taken with suicidal intent and report of 49 cases.

Dr. O'Hara recited laughable experiences among 49 cases of attempted suicide. Morphine is the favorite vehicle, and carbolic acid the most deadly, in his experience. Of 49 cases, only three died. He gave as reason for his efforts to save them, that there might be more space in the beyond, for the medical fraternity.

During his talk he gave chemical tests for poisons mentioned, which are;

Morphine sol. with H. No. 3 gives Orange Red color.

Carbolic acid with Ferric Chloride, intense Blue.

Cocaine with Ag. No. 3, white precip. insol. in H. No. 3.

Chloral, Chloroform odor heated with KOH. Strychnine, in H<sub>2</sub>SO<sub>4</sub>, Violet streak, when Potass. Dichromate is passed through the sol., on white plate.

Hydrarg. Bichlorid, intense yellow with KOH.

All of these reagents are in the office of the average doctor.

His antidotes are practical and to the point. A doctor has no time to carry a drug store to a case. Apomorphine Hydrochlor, 1-100 gr. hypodermically, has in O'Hara's hands produced violent emesis in two to three minutes. Strychnine for morphine and vice versa; alcohol for carbolic acid; stimulants for cocaine; strychnine for chloral; and egg albumen for mercury, are the antidotes usually employed by him.

He explained the advantages and disadvantages of the stomach siphon. Also gave a description of cocaine and morphine fiends, as well as the victims of "knock out drops." He gave a resume of symptoms of each kind of poison mentioned.

In the discussion S. E. Munson spoke of a case who had taken a dram of morphia, he used stomach pump, apomorphia, hot and cold douches in bath tub, finally died after about 30 hours, the secretions having all stopped several hours before.

B. B. Griffith spoke of some children who had eaten roach paste, thinking it was candy,



causing sulphur poisoning, they all suffered severely and complained of intense nausea and burning along the esophagus and in the stomach. There is no antidote but should avoid grease or oils. In these cases he gave large quantities of lime water which relieved the intense burning they all died in from six to ten hours after eating the paste.

G. N. Kreider presented two cases, in the first, the nose was nearly covered with cancerous growth, he had been treated by several physicians, but had received no benefit, after three months treatment with the X-Ray he seems entirely well. Case No. 2 was cancer of left breast which has shown decided improvement under the same treatment.

Walter Ryan spoke of two cases of extra-uterine pregnancy presenting the ruptured tube in each, he also presented several gall stones and a stone taken from the appendix post mortem. It resembled a gall stone. The Society adjourned.

Percy Louis Taylor,  
Official Reporter.

The Cumberland County Medical Society will be organized in the near future.

The Edgar County Medical Society was organized at Paris, Feb. 27, 1903. Full report in our next issue.

The Whiteside County Medical Society. Secretary Finis Perdue, Treasurer J. F. Keefer, and the members of this Society deserve much credit for a letter recently forwarded to Treasurer Brown. Treasurer Keefer says: I forward you draft for \$48.00 and the names of sixteen members of this Society to whom you are to forward the Journal for the year 1903. The list is not a complete one as a few have not yet paid up and some new ones will doubtless be added soon. I will therefore make a later remittance.

The Jackson County Medical Society. The meeting was called to order by President Silvey at Dr. Essicks office, Murphysboro, Dec. 1, 1902. Minutes of last meeting read and approved.

Election of officers for 1903: President, J. T. McAnally, Carbondale; Vice-President, O. F. Daniel, Murphysboro; Secretary, W. C. Hill, Murphysboro; Assistant Secretary, Munroe Etherton, Carbondale; Treasurer, O. B. Omsby, Murphysboro. Board of Arbitrators, F. A. Miner, J. C. Etherton, Chas. E. Riseling; Program Committee, Chas. E. Riseling, W. C. Hill.

Adjournment to meet in Carbondale at Dr. McAnally's office, March 19th.

W. C. Hill, Official Reporter.

The Decatur Medical Society held its second annual banquet at the Decatur Hotel on Friday evening, January 23. Covers were laid for forty-six and a delightful evening was enjoyed by all. President Samuel J. Bumstead acted as toastmaster and interspersed the following toasts between the various courses of the repast:

The Morale of our Profession, E. A. Morgan;  
The Humorous Side of our Profession, W. C.

Wood; The Pathos of Medicine, W. A. Dixon; Looking Backward, D. T. Kyner; Some Possibilities of Surgery, William Barnes; The Country Doctor, J. S. C. Cussins; Our Profession Across the Ocean, S. E. McClelland; Our Relation to Public Affairs, J. N. Randall; Our Professional Parasites, Cass Chenoweth; A Glimpse Into the Future, John T. Miller.

Lynn M. Barnes,  
Official Reporter.

The Rock Island County Medical Society held the January and February meetings in Rock Island on the 13th of January and the 20th of February. About twenty members were present at each meeting. The scientific work of both meetings was devoted to a consideration of the subject of rheumatism, acute and chronic.

At the January meeting a paper on **Acute Rheumatism** was read by J. H. Gardiner of Moline. The paper was followed by a discussion of the subject in its various phases, which was participated in by most of those present.

At the February meeting three papers on different phases of chronic rheumatism were read, "**Chronic Rheumatism**," G. G. Craig, Rock Island; "**The Treatment of Chronic Rheumatism**," A. H. Arp, Moline; "**Treatment of Chronic Rheumatism by Electricity**," G. L. Eyster, Rock Island. The papers were discussed by most of the members present, and also by Harold N. Moyer of Chicago, who entertained the Society by a most interesting talk on the subject.

George L. Eyster,  
Official Reporter.

The McLean County Medical Society met in the Griesheim building, February 5th, with a good attendance.

E. E. Sargent of LeRoy, read a splendid paper on "**Sporadic Cerebro Spinal Meningitis**." He has had a number of cases in his practice and gives a clear clinical picture of this dreadful disease. The secretary read a letter signed by the president and secretary of the State Society, regarding the plan to combine the county, State and National organizations, after some talk on the subject, the president announced that at the March meeting this matter would come up for settlement and he desired a full attendance of the members.

If this plan is adopted it means that the local society will probably lose some of the members now on the roll who do not pay their dues nor attend the meetings. If the local Society is assessed by the State Society, so much per capita, it will be necessary for members to be prompt with their dues.

E. S. Reedy, Official Reporter.

The Pike County Medical Society met in regular session at Dr. Duffield's office in Pittsfield, Jan. 22, 1903.

Members present were H. T. Duffield, L. J. Harvey, B. B. Dunn, Geo. A. Humpert, T. W. Shastid, J. S. Thomas and F. M. Crane.

Dr. Harvey moved the adoption of the Constitution and By-Laws advised by the State and National societies which carried unanimously. Dr. Harvey also moved that this So-

cety send five dollars to the Legislative Committee of the State Society. Carried.

T. W. Shastid read a paper on "Some of My Views on Electricity." L. J. Harvey read a paper on "Myxoedema" describing and illustrating his case.

G. H. Humpert reported a case of puerperal fever.

B. B. Dunn reported a case of unusual dermatitis.

All the subjects were freely discussed by the members present.

R. H. Main, Official Reporter.

The Fayette County Medical Society was organized at Vandalia on Feb. 4, 1903, with the following officers: President, Moses Haynes, Secretary, Asa L. T. Williams; Treasurer, F. M. Enriken. The Constitution and By-Laws as recommended by the A. M. A., was adopted and the Society will meet quarterly.

Eight of the thirty-two physicians in the county were present and if you will send each physician in the county sample copies of the Journal for March and April, I feel that it will aid us very much in increasing our membership.

#### Physicians of Fayette County.

Moses Haynes, Bingham.  
W. B. Shelton, Bingham.  
G. W. Andrews, Ramsey.  
E. P. Staff, Ramsey.  
G. R. VanRankin, Ramsey.  
Chas. Welch, Ramsey.  
J. C. Hudspeth, Vera.  
S. J. Bassett, St. Elmo.  
C. W. Durst, St. Elmo.  
E. W. Farthing, St. Elmo.  
H. L. Rodgers, St. Elmo.  
E. W. Brooks, St. Elmo.  
L. E. Turney, Brownstown.  
Solomon Turney, Brownstown.  
Geo. A. Martin, Brownstown.  
M. E. Heppner, Laclede.  
P. C. Stevens, London.  
John Akester, Farina.  
A. C. Davis, Farina.  
J. B. Holsom, Farina.  
T. B. Childs, Shobonier.  
O. C. Pollock, Shobonier.  
A. E. Greer, Rural Route No. 1, Vandalia.  
H. D. Smith, Vandalia.  
J. H. Wallace, Vandalia.  
L. L. Morey, Vandalia.  
F. M. Entrekin, Vandalia.  
C. A. Higinbotom, Vandalia.  
Geo. Greer, Vandalia.  
G. M. Bassett, Vandalia.  
F. A. Gaige, Vandalia.  
A. L. T. Williams, Vandalia.  
J. T. Reeves, Rural Route No. 2, Vandalia.

Asa L. T. Williams,  
Official Reporter.

The Vermilion County Medical Society was called to order by H. P. Becker in the city hall, Danville, Ill., Feb. 9th, 1903, at 8:25 P. M.

Minutes of January meeting read and adopted.

The board of censors reported favorably on the name of A. M. Miller followed by his election to membership.

The essayist for the evening was not present so his subject of "So-called Billiousness" was discussed at some length.

Cases were reported by T. E. Walton, Benj. Gleeson and E. M. Smith. The new certificate, showing us to be incorporated as a branch of the State Society, was received and ordered to be framed and retained among the officers of the Society for future use.

The assessment plan as proposed by the State Society was discussed and favored by a unanimous vote.

A motion that the Vermilion County Medical Society strongly favor the movement to secure medical reciprocity between the various states received a unanimous vote.

E. E. Clark, Official Reporter.

The Peoria City Medical Society met January 20, 1903, at the National hotel, and was called to order by the president, R. A. Hanna.

The application of James J. Toalson, 308 Y. M. C. A. building, Peoria, Ill., was received. On motion by J. W. Hensley the application was referred to the board of censors.

O. B. Will suggested the appointing of a member to the house of delegates at an early date, and urged that a member be appointed, who will understand the Society's wishes on important questions which will come up. R. A. Kerr moved that the delegate be appointed by the president. Carried.

H. M. Sedgwick read a paper on the "Dynamics of Disease." The paper showed the result of a great deal of care and study and reflected great credit on the essayist. Facts concerning the causation of disease were placed before the Society in a comprehensive and instructive manner. The discussion was led by J. J. L. Finnell, followed by O. B. Will and R. A. Kerr.

J. J. L. Finnell presented a case of some growth near the left mammary gland in a young girl 16 years old, which was examined by the members of the Society.

The members present were Sedgwick, Will, Hanna, Finnell, Kanne, Kerr, Hensley, Brobst, Corcoran, Eckard, Stephenson, Sutton, Frederika Zeller, and Collins.

C. U. Collins, Official Reporter.

The Peoria City Medical Society met Tuesday evening, Feb. 3, 1903, at the National hotel, and was called to order by the President, Robt. A. Hanna. Minutes were read and approved.

O. B. Will reported for the committee on resolutions in regard to the death of Dr. John Murphy, and submitted the following:

The Peoria City Medical Society, in regular session assembled, January 23, 1903, adopted the following report of its special committee:

Whereas, There has come to us announcement of the death on the 21st ult., of the well known and venerable Dr. John Murphy, of this city, one of the earliest members and indeed one of the founders of this organization, therefore be it

Resolved, That while many of us as members of the Peoria City Medical Society have

never had the honor and privilege of close association with Dr. Murphy, in consequence of his practical retirement for many years from the active duties of his profession, we all are brought to realize, either from personal acquaintanceship or from the great reputation that outlives him, his strong character as an eminent scholar and learned physician and practitioner, and one who has made his influence felt not only upon his profession, but upon the progress and philanthropies of the community at large.

Resolved, That in contemplating the professional worth, the scholarly attainments and heroic character of Dr. Murphy, as one of the pioneers in medicine in this State, we feel to accept his long, untiring and useful life as an inspiration to that highest ideal of educational acquirements, professional acumen and skill, which actuated him and his compatriots when they set for us so high a standard of qualifications.

Resolved, That these expressions of our sentiments toward and esteem for the deceased, and all that his aggressive nature has stood for in the history of local medicine and public usefulness, be made a matter of record in the archives of this Society, and a copy of them be transmitted alike to the near relatives of Dr. Murphy, and to the community in general through the public press of this city.

M. S. Marcy moved that the resolutions be adopted and the suggestions carried out. Carried.

E. M. Sutton asked some questions concerning the Code of Ethics which was informally discussed by those present.

A letter was read from M. L. Harris and E. Weis, president and secretary of the State Medical Society.

O. B. Will made a motion that the discussion of this letter be made a special order of business at the next meeting. Carried.

J. C. Roberts read an excellent paper on the early diagnosis of **Chronic Interstitial Nephritis**, which was discussed by Drs. Kanne, E. L. Davis, Marcy, Corcoran, Brobst, Whitten and Sutton.

The Board of Censors reported favorably on the application of J. J. Toalson. A motion was made that the secretary be instructed to cast the entire vote of the Society for Dr. Toalson. Carried.

J. J. Toalson, 308 Y. M. C. A. Bldg., Peoria, Ill., was duly elected a member of the Society.

The members present were Hanna, Horwitz, Brobst, Roberts, Will, Roskoten, Marcy, Kerr, Kanne, Sutton, E. L. Davis, Whitten, Hayes, Collins, Corcoran and Stephenson.

C. U. Collins, Official Reporter.

The **Peoria City Medical Society** met Tuesday evening, Feb. 17, 1903, at the National Hotel, and was called to order by the President, Robert A. Hanna. Minutes read and approved.

The application of M. V. Gunn, of El Paso, Ill., was received and referred to the Board of Censors.

The President appointed R. A. Kerr as a delegate from the Society to the House of Dele-

gates at the next meeting of the Illinois State Medical Society.

A bill for \$5.00 was received from Cole Bros., florists, for the floral emblem sent to Dr. Murphy's funeral. E. M. Eckard moved that the bill be allowed and an order drawn on the treasury for the amount. Carried.

A letter was read from the President and Secretary of the State Medical Society regarding the new plan of organization.

O. B. Will made a motion that the plan be adopted, and the Society's delegate be instructed to vote for it at the next meeting of the State Society. Carried.

A. J. Kanne made a motion that a committee of two be appointed to amend the Constitution to conform to the new plan. Carried. The President appointed Drs. Kanne and Will.

E. Franc Morrill read an exceedingly interesting and exhaustive paper on **Puerperal Sepsis**, which was discussed by Drs. Will, J. S. Miller, Marcy, Waln, Sutton, Hensley, C. E. Davis, and S. M. Miller.

J. C. Roberts made a motion that a vote of thanks be extended to Dr. Morrill for the presentation to the Society of her valuable paper. Carried.

The committee appointed to amend the Constitution reported as follows:

In obedience to the motion passed by the Peoria City Medical Society, the following amendments to its existing Constitution is hereby proposed:

That Sec. II, Art. 9, be so amended as to read: "The annual contribution of three dollars shall be due and payable by each member on the first day of April.

That Sec. I, Art. 9, be changed to read: "And three dollars for dues," instead of two dollars for dues.

That Sec. III, Art. 9, be changed to read: "April 1st of each year," instead of Oct. 1st of each year.

A. J. Kanne,  
O. B. Will.

A motion was made to refer the amendment back to the committee to change the dues from three dollars to four dollars. Carried.

A letter was read from M. L. Harris, President of the Illinois State Medical Society, in answer to an invitation from the Program Committee, saying that he would come to Peoria on March 3d, and would read a paper entitled, "**Some Surgical Infections due to the Colon Bacillus.**"

E. M. Sutton and H. H. Whitten exhibited pathological specimens.

The members present were Hanna, Roberts, Will, Toalson, J. S. Miller, J. V. Studer, Marcy, Eckard, Weber, Waln, Sutton, McFadden, Hensley, Whitten, Corcoran, Horwitz, Morrill, E. L. Davis, C. E. Davis, Lucas, S. M. Miller, Kanne, Collins, Schoaff, Finnell, Roskoten, Green and Plummer.

C. U. Collins, Official Reporter.



The North Central District Medical Society met Dec. 2-3, 1902. The following paper was read and discussed:

## ECTOPIC GESTATION WITH A REPORT OF CASES.

By E. E. Perisho, M. D., Ancona.

Recently I have had an interesting experience with a few cases of Ectopic Gestation and inasmuch as the average general practitioner considers this disease so rare as to give it but little thought, I desire to give you my experience and at the same time briefly review the literature with you.

The subject of Ectopic Gestation dates back centuries ago, but nearly all of our present knowledge of it has been developed within the last thirty years, previous to that time there was but little known as to its true pathology or clinical course and I am told it was considered something unusual for a surgeon to be able to report three or four cases from his entire practice, but of recent years with our improved facilities for studying these cases they have been found to occur comparatively frequently if correctly diagnosed. I have personal knowledge of abdominal surgeons having series of three and four cases occurring within one week instead of a lifetime. Our present medical literature is full of articles bearing on this topic. I have collected twenty-five American articles with a report of thirty-seven cases that have been published within the last year, thus making it about as common as any other subject.

It is exceedingly difficult to obtain any satisfactory evidence as to the frequency of ectopic compared with normal gestation as there is no statistics and the present opinions are so variable. I think however the prevailing opinion is that it occurs once in about 2,000 cases. Formad found in 3,500 general autopsies, 31 ectopic pregnancies or 1 per cent which is considerably higher than generally conceded, but if we had some way of ascertaining its exact ratio to normal pregnancy it would undoubtedly be much higher than any percentage obtained from general autopsies.

To properly present this whole subject would take more time than allowed to me and it would be unnecessary, but in order for us as general practitioners to be able to recognize this trouble in all its forms and to know the probable outcome of each individual case, it is very necessary that we should have a thorough knowledge as to the varieties in regard to the location and development of the embryo and for that reason I wish to review that portion of the literature with you.

The classification of ectopic gestation is divided into four main groups as to the location of the embryo within the reproductive organs, namely, Tubal, Ovarian, Tubo-ovarian and Cornual.

Tubal gestation includes the majority of all ectopic gestation and is sub-divided into three groups, namely, Interstitial, Isthmic and Ampullar.

Interstitial, the less frequent of the tubal varieties, is where the ovum takes lodgment in that part of the tube which traverses the uterine wall and the foetus is in a cavity formed in the substance of the uterine wall. This cavity may extend on into that of the uterus, causing what is known as tubo-uterine pregnancy. The tube at this point is incapable of much distention, thus rendering it extremely dangerous because of the liability to early rupture into the peritoneal cavity with a fatal internal hemorrhage; or the foetus may rupture back into the uterine cavity even later than the fourth month and go on to full term as normal pregnancy, or it may terminate in ordinary abortion.

The isthmic variety is where the ovum takes lodgment in the isthmus, or the inner half of the tube, this occurs more frequently than the interstitial, but far less than the ampullar.

The ampullar form is where the ovum takes its attachment in the ampulla or outer third of the tube as it is much larger here and seems to be the favorite location for the lodgment of the ovum. The great majority of all ectopic gestations are of this variety.

In tubal pregnancy rupture may take place any time from a few weeks to the third, or occasionally, the fourth month, but more often about the second month. If rupture occurs early the hemorrhage is usually light and encysted in tissue of the broad ligament, causing a pelvic hematoma which will clot and be gradually absorbed; but if occurring after the second month the hemorrhage is usually intra-peritoneal and very heavy and may cause death within a few hours. If the placenta is still attached and the embryonic coverings are not broken, the pregnancy may go on to full term with the foetus either surrounded by the layers of the broad ligament, or loose in the abdominal cavity.

"Charles Gilbert Davis,"<sup>2</sup> of Chicago, reported a case of the latter type which he delivered at full term by the vagina, the placenta being attached to the abdominal wall; also one by "E. E. Root,"<sup>3</sup> of Salt Lake City, delivered through an abdominal incision with a 6 lb. live child. But to go to full term, after rupture, is of rare occurrence.

If the membranes are only partially detached, it gives rise to repeated and dangerous hemorrhages continuing from a few days to weeks, or recurring irregularly for a long time.

In the ampullar variety, the foetus may be expelled through the osfium abdominale, into the abdominal cavity, causing what is known as tubal abortion, and the foetus is called tubal mole. This condition usually occurs before the eighth week.

Ovarian pregnancy is now one of much doubt. The history dates back two centuries, when they regarded all ectopic pregnancy, ovarian; but, of late years, with our improved facilities for examination, and advanced knowledge of embryology, primary ovarian pregnancy is very much doubted. I find only a limited number reported. The three of most interest being the cases of G. P. Anning and Mr. Harry Littlewood, the celebrated case of Cath-

rine Van Tussenbrock<sup>4</sup>, and one by Wm. H. Wathen<sup>5</sup>, of Louisville. All have created more or less discussion as to their primary origin, but as to whether ovarian pregnancy does occur or not it will suffice me to say that it is very rare.

Tubo-ovarian pregnancy is where the embryo develops in the fimbriae of the tube or on the surface of the ovary, the placenta rapidly covers both ovary and the fimbriae; and the ovum develops in a sack formed partially by the tube and the ovary. This variety is very rare.

Cornual pregnancy takes place in an ill-formed horn of a bicornate uterus. This is also a rare form, there being only 19 ruptured cases on record. Their diagnosis, symptoms and treatment are the same as other forms of ectopic pregnancies, rupture usually occurs later and hemorrhage is very profuse. If rupture from any of these varieties occurs early and the mother survives, the future condition will vary accordingly. If the embryo is still retained in its envelope as a hematoma, absorption is the ultimate result, but very slow. If the membrane has been broken and the hemorrhage is in the abdominal cavity, absorption usually takes place very quickly; but when gestation has advanced for several months it may give rise to a variety of conditions, i. e., it may become infected and undergo decomposition and suppuration and, as a result, the patient may succumb to exhaustion from peritonitis and blood poison, or it may ulcerate into the intestines, vagina, bladder or through the abdominal wall and lead to recovery.

The foetus may become impregnated with lime salts producing a partial calcification and remain in the abdominal cavity for years. Chiari<sup>6</sup>, reported a case in which the foetus was mummified and carried for fifty years. Ectopic pregnancy, like intra-uterine, may be single or multiple, all extra-uterine or one or more may be extra-uterine, and the others intra-uterine, producing what is known as combined intra and extra uterine pregnancy, of which our literature contains about 70 reported cases.

Double or twin ectopic pregnancies are not rare, but as to triple, I have been able to find but two reported cases; that of Sanger,<sup>7</sup> of Lelapsic, in which there was twin pregnancy in the wall of the uterus, and a third ovum in the fimbriated end of the right tube, and a case of Wilmer Krusen<sup>8</sup>, of Philadelphia, in which there was a ruptured right tube with three perfectly formed foetuses.

I have reviewed all the above research of literature to recall all the different varieties that we may meet in general practice. As to symptoms, I wish to report three cases occurring in my practice all within one year, which, of course, is very unusual.

Case I. Mrs. I. H., age 32, married nine years, mother of six children, the youngest 18 months still nursing. No miscarriages, or menstrual trouble, last menstruation in November. In January about the expected time for the menses in the second month, she was taken with cramps and a heavy flow of blood, which she took to be a severe attack of dysmenorrhea. She re-

mained in bed 12 hours, when the cramps subsided, leaving her very weak and extremely sore, over the lower abdomen, to movement or touch; this soreness with a bloody slimy discharge kept up for three weeks, at which time she was again taken with very severe cramps resembling labor pains and an increased flow. Examination at this time revealed an extremely sensitive enlarged uterus with a large boggy mass posterior in Douglas fossa, temp. 101, pulse 110, patient was unable to move or urinate and suffered increased pain whenever the bladder filled, thus necessitating frequent catheterization. In three days the pains subsided and general septic symptoms became more marked, temp. 103, pulse 122, abdomen tympanic and the bladder still requiring catheterization. Patient was then removed to a hospital where a vaginal drain was made posterior to the uterus into the bulging mass which proved to be a hematoma, which was drained of its dark degenerated blood. Patient made a prompt recovery.

Case II. Mrs. G. M., age 22, married three yrs., mother of one child two years of age. No miscarriages, menstruation always irregular and painful; last menstruation in August. Six weeks from that date patient was taken suddenly with very severe cramps and menstrual flow, which required repeated doses of morphine hypodermatically to quiet. There was no symptoms of internal hemorrhage or shock aside from the severe pains. Vaginal examination revealed nothing except a sensitive uterus, and especially so, over the right tube and ovary. The cramps subsided in two days with a developing peritonitis which lasted ten days when patient was allowed to sit up a short time, then a second attack developed same as first, except menstrual discharge was less but peritonitis more severe than former attack with general abdominal pain and marked tympanites. Vaginal examination, at this time, revealed an enlarged and extremely sensitive tube. This attack lasted two weeks when the patient was again allowed to sit up for a short time when she developed a third attack, similar to the second, which lasted another two weeks; after which there was a very large boggy mass to the right of the uterus which could be felt externally in the right iliac region. There was a bloody slimy cervical discharge through all the course. Nov. 20th, almost two months from first attack, patient was removed to a hospital and a laparotomy performed to find a hematoma in the right tube with very extensive adhesions of all the pelvic organs as a result of the peritonitis. Patient made a prompt recovery returning home in three weeks.

Case III. Mrs. F. H., age 27, married six years, mother of two children, the youngest 18 months, still nursing. No menstrual trouble, no miscarriages. Last menstruation Dec. 1. Jan. 18th, was seized by a very sharp cutting pain in right side, over her ovary, as she termed it. This subsided in a short time, so as to allow her to go on with her morning's house work for about three-fourths of an hour, when the cramps returned with increased severity. This time the pain was all



through the pelvis and especially in the rectum. Patient fainted, remained cynotic and cold. Pulse very weak and irregular, and in pronounced shock until slightly relieved by medication; but remained in pain and unable to change position or urinate for 18 hours. Vaginal examination revealed an apparently normal uterus and tubes, but extremely sensitive to touch and especially over the region of the right tube. In 24 hours peritonitis began to develop with a range of temperature of 101 to 102 for one week, lips conjunctiva very pale, general abdominal tenderness especially over the region of the pelvic organs. There was no cervical discharge until the fourth day when a bloody, slimy discharge appeared. There was no enlargement of the tubes or uterus at any time. At the end of the first week, temp. reached 99½ when the patient was removed to a hospital for a laparotomy, to find the abdomen full of clotted blood, which was scooped out by the hands full sufficient to locate the right tube which was found to contain the product of conception in the ampulla, with a marked rent in the wall of the tube allowing a free hemorrhage to take place into the abdominal cavity, thus explaining why we could not palpate any enlargement before the operation. The ruptured tube, as well as inflamed appendix and blood clots were removed and the abdominal cavity closed. Patient made a prompt recovery returning home in three weeks.

In cases I and II there were severe pelvic pains followed by peritonitis and an enlargement to be felt, but no shock. In case III there was a distinct shock but no enlargement as the hemorrhage was in the abdominal cavity. In all three cases there was a bloody slimy cervical discharge which I would emphasize as being an important secondary symptom.

As to the treatment of these cases, surgical treatment is the only safe procedure, but that should seldom be done while the patient is in shock or a prostrated condition. She should be kept quiet and stimulated until she rallies and then be operated upon; as a very small number die in the first hemorrhage and shock if they are kept quiet and stimulated by the ordinary stimulants and the saline infusion, if needed.

J. W. Elliott,<sup>9</sup> of Boston, gives a report of the Massachusetts General Hospital with a record for five years, in which time 75 cases of ruptured ectopic gestation had been operated upon, with three deaths, or a mortality of 4 per cent, which is exceedingly good, considering the kind of cases usually taken to a hospital.

The records show the three that died were operated on soon after entrance while in a more or less collapsed state.

The clinical records of these cases teach us that they will almost invariably rally from the shock to run a sub-acute or chronic course with more or less peritonitis for a week or more, when they usually develop another attack like the first which will be more or less severe. This history may run on with repeated

attacks for weeks or months with a fair percentage of complete recoveries.

Therefore, the safe and preferable time to operate, is just as soon as they rally from shock and the peritonitis, if it has been severe, and before the second attack occurs.

1. Dudley, Dis. of Women.
2. American Medicine, Oct. 19, 1901.
3. American Journal of Surg. and Gynecology, Aug., 1902.
4. British Medical Journal, Jan. 13, 1901.
5. American Med. Jour., Aug. 3, 1901.
6. Dudley, Dis. of Women.
7. Centralblatt fuer Gynecologie.
8. American Med. Jour., Jan. 4, 1902.
9. American Med. Journal, Feb. 22, 1902.

The Clinical Society of the New York Polyclinic Medical School and Hospital held a meeting, Oct. 6, 1902, with the President, Alexander Lyle, in the chair.

**Fracture of the Patella.**—J. A. Bodine exhibited a patient with the following history: Six weeks ago this patient sustained a fracture of the patella. As in the great majority of cases in which the line of fracture is transverse in direction, the cause was a sudden, involuntary contraction of the quadriceps muscle, while the leg was in opposed flexion. The fact that he is already a cripple in the other leg demanded that bony union, with good functional results be obtained, and a stringent financial condition urged the accomplishment of this in the shortest space of time possible. I present him to you tonight ready to resume his occupation with a perfectly functioning leg.

"In my opinion, all cases of fracture of the patella should be treated by open suture, as was done in this case, provided it is done by a trained surgeon. Primary union is absolutely essential. The most difficult accomplishment in surgery today is not mechanical skill in operating, but comparative cleanliness in technique, with minimized traumatism to tissues. This attainment is only relatively possible to the trained operator, and absolutely impossible to the general practitioner who occasionally operates."

The treatment of fractured patella by mechanical means, splints, strapping, subcutaneous suture, etc., is irrational and wrong fundamentally. If the line of fracture extends laterally into the expansion of the patella capsule, with wide separation of the fragments, in but very few cases will any method other than that by open suture produce a perfectly functioning leg. The reason is simple. When the patella fractures by muscular contraction over a bent knee the stretched capsule, when it ruptures, projects beyond the edges of the fragments and, as pointed out by Macewen years ago, falls between the broken fragments. The interposition of this ever present fibroperiosteal fringe is an obvious obstruction to bony contact or bony union, and must be removed by bony operation. Again, blood from the broken bones and torn capsule fills the intervening space and distends the joint, if this is opened, with clotted blood. What becomes of this aseptic bloodclot? On the same great proven principle of Schede's aseptic bloodclot



in bone surgery, it becomes more or less organized into living, fibrous tissue, fixing the joint and surrounding tissues in a condition of more or less rigidity and ankylosis. Obviously the thing to do is to remove both the bloodclot and the capsular fringe. The wonder is not that, by the old method, the joint is more or less impaired, but that it functionates at all. Yet, I report, that if one is not a trained aseptician, it is better to accept this result; at least it will not kill the patient from sepsis.

"The simplicity and ease of accomplishment which characterizes the result here presented to you is remarkable. A quarter of a one per cent. solution of cocaine was injected before making a transverse skin incision. As the patella lies subcutaneously and its fibrous periosteal capsule is already ruptured from the accident, this skin incision admits one directly to the field of operation. Nothing remains to be done but to wash away the blood clots, remove the interposed fringe of capsule, and suture, not the bone, but the capsular rent, as well as any rent extending into the lateral capsular expansion. In a great many cases, contrary to text-book teaching of the present day, the knee joint is not opened by the accident, nor invaded by the operation. This is due to the fact that the closed synovial sac of the joint is frequently reflected from the posterior surface of the patella at or near the median line. Consequently, any fracture below the level of this line of reflection does not enter the general articular cavity. This condition of extra-articular safety I have encountered several times.

The skin incision being closed, if the work has been done aseptically, there is no swelling, no pain, no fever. Beginning about the third week, carefully graduated passive motion, with daily massage is inaugurated. At the end of the sixth week a perfect cure will result, as exemplified by this case presented tonight."

W. R. Townsend opened the discussion by saying that it is unusual to find a surgeon who never encounters sepsis as a result of his work. All surgeons should be clean, and practically speaking, all are in a majority of cases, but surgeons have not reached the joint of perfect asepsis. Especially in serious cases, such as opening the knee-joint, if an operator can avoid suppuration, so much the better, but there are so many possibilities of infection that he would hesitate before undertaking this operation. The growth of small hospitals throughout the country is very rapid, and he thought that the surgery of the future should be done in such places. He did not believe that a simple result can be counted on in every case of fractured patella by the method advocated by Dr. Bodine, and he said that he had seen some very good results by the old method, and in many instances in which it failed the fault was not due so much to the method as to the operator. Bony union is always better than fibrous union; yet he would hesitate very much in saying that every fractured patella should be treated by the open method.

W. H. Luckett said that if every case that was operated on turned out as successfully as

Dr. Bodine's case did, he would be inclined to advocate the open method in all instances, but, unfortunately, all surgeons are not aseptic. He did not agree with Dr. Bodine that blood in a synovial cavity goes through the same process or organization as blood in a bone cavity. Here the blood is in contact with a very rapidly absorbing surface, but more often blood exuded into an articular cavity will be absorbed rather than become organized. The most important treatment in connection with fracture of the patella is massage, applied particularly to the quadriceps muscle, and this should be forcible enough to allow relaxation of that muscle and juxtaposition of the fractured fragments of the patella. The bone must be retained in place by straps and splints. The massage should be done properly by one who thoroughly understands the principles involved. This method was first introduced, he thought, by Howard Lillenthal.

W. C. Gilday said that he had a patient who was treated by the old method, and the result was most unsatisfactory. He had been with Dr. Bodine when he operated on the patient presented this evening and having seen the result, he should hereafter treat all his cases in that manner.

Dr. Bodine closed the discussion. He said in reply to Dr. Luckett that he did not mean to imply that every hemorrhage into the knee-joint becomes organized on the principle of Shede's moist bloodclot, but he was quite sure that this hemorrhage into the cavity of the knee and into the tissues surrounding the knee is a cause, in part at least, of the many cases of rigidity or partial ankylosis in fracture of the patella; and, furthermore, he was sure this rigidity is caused by a more or less complete organization of the bloodclot into the living tissue. He had never seen the statement emphasized that in fracture of the patella the general articular cavity is not opened. This statement was based on the fact that twice in his experience he had encountered a condition of an intact synovial membrane beneath the broken fragments. It is a well-known anatomical fact that the reflection of the synovial membrane on the posterior surface of the patella as high as its middle posterior line, frequently occurs, so that all fractures of this bone occurring below the level of this line of reflection would not involve the general synovial cavity of the joint. A knee-joint filled with a bloodclot, even though there is no external wound, may become infected through the medium of the circulation. He believes that the frequent occurrence of synovial osteomyelitis is sufficient proof of this statement. He had known of occurrences of violent infection within the knee-joint following fracture of the patella when no operation had been attempted. If this infection were due to an external wound in the surface he was unable to find the point of entrance.

#### A Case of Syphilis.

D. A. Sinclair exhibited a man with syphilis. The initial lesion was on the glans penis. He presented large, secondary squamous syphilides of the abdomen and back, large condylomata about the anus and enlarged inguinal and epi-

thoracic glands. The patient had been seen about a month ago, and had been treated by intramuscular injections of salicylate of mercury suspended in liquid benzoinal, having received but three injections, one week apart.

The speaker desired especially to call attention to the method of treatment and the rapid results obtained. The salicylate of mercury is an insoluble preparation, and dose of which is  $1\frac{1}{2}$  grains. On account of its insolubility, it requires five or six days for it to come absorbed, so that the patient receives a regular, scientific dose each day. It is non-irritating and does not produce abscesses. The marvelous change seen in this patient's condition was nothing more than one might expect from this form of treatment. In the speaker's opinion the salicylate is superior to the soluble preparations of mercury and also to the other insoluble mercurials, such as calomel. Hypodermatic medication is better than internal as it enables the physician to keep the patient more perfectly under control.

A. R. Robinson said that he thought this method of intra-muscular injection painful, and not so good as that of taking pills and other internal medicines. It kept the patient constantly running to the doctor.

C. G. Child said that he wished to indorse Dr. Sinclair's statements with regard to the efficiency of the subcutaneous injections of salicylate of mercury in the treatment of syphilis, especially in those cases of the squamo-papillomatous variety. He began to use it three years ago in the venereal wards of the City Hospital, using it exclusively in both the male and female wards, and in more than 100 cases in which there was a total of nearly 1,000 injections, not one of the patients showed any bad after-effects either in the way of inflammation, induration or abscess formation. The injections were made in the deep tissues of the buttock and under the scapula. One, or at the most, two injections a week were all that were ever given. In the papular varieties a marked effect was seen in from one to two days after the first injection was given. He had experimented to some extent with the different solutions used as media for the salicylate, and found that the one which gave the most satisfactory results was liquid albolene.

Dr. Sinclair, in answer to Dr. Robinson's remarks, said that the patient received an injection but once a week, and that it was not painful. It was less compromising than for a man to be carrying a little box of pills around in his pocket.

### Three Cases of Tetanus.

W. H. Lockett also reported three cases of tetanus. The first patient was admitted into the Harlem Hospital with a blank cartridge wound of the palm of the left hand. Within ten hours he had developed all the symptoms of a most pronounced case of tetanus. Treatment was by the usual method—potassium bromide, chloral hydrate, hot baths, etc. The second case was that of a wound in the palm of the hand from a blank cartridge. Symptoms of tetanus developed on the eighth day—opisthotonos, lockjaw, and local tetanus of the left hand. Treated by injections of the New

York Board of Health antitetanic serum in extraordinarily large quantities between the third and fourth lumbar vertebrae into the sub-arachnoid cavity. After the cerebrospinal fluid had been withdrawn the patient received an injection daily for about 10 days, getting from 8 to 10 cc. at each injection, from 10 to 45 minims of cerebrospinal fluid being withdrawn previous to each injection. From the very start his symptoms improved. The patient was discharged from the hospital cured. The speaker believed this to be the first time that this method was used in this country.

The third case was a more pronounced type of tetanus than the preceding one. It occurred in a boy, nine years old, who jumped over a garden fence and cut his left wrist on the neck of a broken bottle. The wound was sutured at one of the hospitals. On the sixth day the boy developed stiffness of the muscles of the neck of the abdomen, and of the jaw, in the order given. He was admitted into the Harlem Hospital, the wound was opened, several particles of dirt were removed therefrom, and the wound was dressed. Very marked symptoms of tetanus were present. This boy, although in appearance much worse than the preceding one, recovered more rapidly under treatment, only five injections being necessary. This was attributed to the fact that preceding each injection, all of the cerebro-spinal fluid possible was removed, as much as 560 minims in five days. The patient was discharged, cured, about two and one-half weeks after admission. The reason for withdrawing this fluid is on account of its great toxicity, it being much more toxic than the blood of a tetanus patient. These patients, except the first one, received no internal medication whatever.

The paper of the evening was read by Charles Gilmore Kerley, the subject being

### Empyema.

The author began his paper with the statement that empyema is the result of infection of the pleura with pathogenic organisms. A large majority of the cases show that pneumococcus is in the pure culture; the streptococcus and the staphylococcus, alone or in combination with the pneumococcus, are seen less frequently. Tuberculosis is rarely a cause of empyema. The disease is rarely primary, being secondary to pneumonia in fully ninety-five per cent of cases. The symptomatology varies, depending on the nature and severity of the primary disease. He cautioned against confusing empyema with malaria, typhoid fever, unresolved pneumonia, and tuberculosis. The average case of empyema following pneumonia he described as follows:

A child has pneumonia; it runs the usual course of fever, respiration, pulse and prostration; after a time, from six to twelve days possibly, an improvement in the symptoms is noticed; the pulse and respiration become slower and the child brighter; the temperature range for twenty-four hours is lower; during the height of the fever it was perhaps from 104 degrees to 105 degrees, F.; now it ranges from 100 to 102 degrees, occasionally touching at 99 degrees. Behaving in this way for a few days, it is soon noticed that it is lower in the morn-



ing than in the evening, although the evening temperature might not be high, perhaps not over 102 degrees, occasionally reaching 103 degrees. The pulse and respiration both remain accelerated and the child coughs. These symptoms may continue for weeks if the true nature of the case is not made out.

Forty-three cases comprise the number seen by the author, in patients from the various walks of life. Some developed under his own observation, and others were first seen after a long illness. In all of the cases there were three symptoms in common, cough, fever (higher in the evening), and accelerated respiration.

Under physical signs, inspection of the chest was referred to as being valuable in that there is a difference of mobility of the two sides; the diseased side rests, the sound side is active. An increase in the measurement of the diseased side is in itself of no diagnostic value. He cited cases in which the sound side was the larger. This is apt to be the case when there is a small amount of fluid in the pleurocavity or when absorption has already begun.

Displacement of the apex beat of the heart upward and to the right is one of the most reliable signs of fluid in the left pleural cavity. Under auscultation it is claimed that fluid always produces a deviation from the normal respiratory sounds, but not always the same changes will be observed. There may be bronchial breathing and bronchial voice when the chest is full of fluid, or greatly diminished and weakened breathing and weakened voice sounds when the amount of fluid is small.

Percussion is considered one of the most valuable aids in diagnosing fluid in the pleural cavity. If there is a moderate amount of fluid, there will be invariably, dullness, and if the amount is considerable there will invariably be flatness. Serum and pus show the same physical signs. There is but one way to differentiate between serum and pus, and this is in the use of the exploring needle, which should always be used to prove the diagnosis. There is no danger in the use of a sterile needle and a properly prepared skin.

As regards treatment, in a recent case in a child under two years of age, incision under local anesthesia is all that is ordinarily required. In older children or in a prolonged case in a young child, the removal of a portion of a rib under gas anesthesia is best. Irrigation of the pleural cavity is not necessary. The dressing should be changed once a day and the tube shortened as the lung expands.

The author concluded as follows: "The disease in every one of the forty-three cases was secondary, and in forty it was secondary to pneumonia. Every child coughed, every one had fever, practically constant, higher in the evening, but rarely going above 103 degrees, F.; every child had accelerated respiration, the chest in each case showing flatness on percussion, and marked changes from the normal in auscultation. Children in whom the disease had existed longer than a week showed marked emaciation.

Adolph Baron opened the discussion by saying that he wanted to mention what Dr. Kerley,

in preparing his paper, had probably overlooked, and that was the necessity for making numerous attempts at aspiration, as one frequently does not draw pus at the first attempt, and the reason for that is that the needles used are not of sufficiently large calibre.

Henry Heiman said that it is generally found by bacteriological examinations of the pus in empyema cases, that the pneumococcus, streptococcus, staphylococcus, or tubercle bacillus, or any of the mixed forms, are responsible for the lesion. When no bacilli are found in the pus, the empyema is generally of a tubercular nature. When this is found it is always well to inoculate several guinea-pigs for a positive diagnosis. It is at times important to decide what kind of an operation is advisable in certain cases and for children of certain ages. The rule adopted by an institution with which he is connected is to incise all patients under one year of age and to resect all patients over one year. This, of course, is not a fixed rule, but may be varied according to indications. It is also of interest to speak of double empyema. Two such cases came under the speaker's observation within two weeks. One patient was resected on both sides, and the other, being rather marasmic, was incised, but two weeks later the child died of persistent broncho-pneumonia and exhaustion. In regard to the empyema necessitatus, one does not see these cases as frequently as formerly, which is almost undoubtedly due to the fact that great advances have been made in the physical diagnosis in children.

W. H. Luckett said that he desired to emphasize what had already been stated in regard to the use of a large aspirating needle in empyema as well as in other cases. He had frequently demonstrated that it is possible to aspirate the chest with negative results, when pus was surely present. This has been illustrated by inserting the point of an aspirating needle into a clot of fibrin removed from the pleural cavity, and failure to draw any of the pus into the cylinder of the syringe. He was conversant with the case of a patient who might be alive today had a large aspirating needle instead of a small one been used. The case was that of a man who had all of the symptoms of a cerebral abscess following an otitis media and mastoiditis. His skull was trephined and the brain aspirated, with negative results. The patient died. At the autopsy it was shown that the aspirating needle had been inserted into the abscess cavity at several points, but the pus was so thick that it did not enter the lumen of the needle. The speaker could not agree with what had been said in reference to an incision through the skin prior to an aspiration. The skin bacillus of Welch is seldom, or at least not necessarily, pus-producing, unless mixed with some other infectious material, and an incision through the skin does not remove the bacillus from the field of operation. He depends on the ordinary methods of cleansing the skin, as for any other operation.

S. S. Roos asked Dr. Kerley to specify what local anesthetic he uses in empyema operations on children. From the number of cases of



aspiration that he has seen carried out without local anesthesia, and without disturbance to the children, he believed that there is no need of an anesthetic of any kind.

Albert Kohn said that the interlobar was the form of empyema diagnosed correctly the least frequently, and this, he thought, was an important point.

J. A. Bodine said that he had had no experience whatever in the diagnosis or treatment of acute pleurisy, especially in children. He called attention to a suggestion made by the late Dr. VanArsdale in connection with the operation of excision of part of a rib for empyema. It refers to the annoying complication or sequel of osteitis or osteomyelitis of the bone ends, when exposed to the discharging pus. The periosteum over the rib is incised and reflected, the proper length of bone excised, and the periosteum sutured in its former position. The incision is now carried between the ribs into the pleural cavity. When the tube is inserted for drainage, the flaccid portion of periosteum gives plenty of space, and yet the ends of the bone are protected from infection. As to the sterilization of the skin, it is well known to be impossible. The normal habitat of the staphylococcus is so deep in the skin as to be beyond the reach of either brush or chemicals. If one wishes this little operation of aspiration to be carried out under absolutely sterile conditions, he must nick the skin with a bistoury, preferably under local anesthesia, and introduce the needle through this nick, and thus avoid any traces of the deeper layers of the skin. It has been his custom to ascertain the pathological cause of empyema; if found to be due to the pneumococcus, the pleural cavity has been treated as a cyst, that is, drained, but not washed out; while if the infection was due to a staphylococcus or streptococcus infection, it is treated as an abscess and irrigated thoroughly.

Dr. Kerley closed the discussion, answering Dr. Roos' question by saying that he had used ether locally in aspirating for empyema.

The Edgar County Medical Society was organized today with 20 members. Constitution and By-Laws similar to the one proposed in "The Journal of the American Medical Association" of August 9, 1902, was adopted.

The following officers were elected: President, A. K. Moseley, Grandview; Vice-President, N. P. Smith, Paris; Secretary, H. McKennan, Paris; Treasurer, C. S. Laughlin, Paris. Delegates: Howard Parker, Edgar; G. F. English, Isabel; J. C. Epperson, Kansas. Committee on Program: H. McKennan, Geo. H. Hunt, W. H. Tenbroeck, all of Paris. Committee on Public Health: E. O. Laughlin, Paris; W. S. Jones, Redmon; J. E. Hite, Kansas. Committee on Entertainment: O. E. Glick, Z. T. Baum, R. S. Lycan, all of Paris.

The regular meetings will be held on the last Wednesday's of March, June, September and December, at 2:00 P. M.

H. McKennan, Official Reporter.

**Wanted**—A first-class microscope. Address, O. H. Rees, M. D., Ogden, Ill.

## New Incorporations.

New Corporations were licensed by the Secretary of State at Springfield, as follows:

Northwestern Guaranty company, Chicago; to provide medical and funeral aid; capital, \$10,000; incorporators, Charles L. Cole, C. C. Pickett, and Daniel P. Roberts.

The Children's Hospital society, Chicago; benevolent; incorporators, Mary E. Plummer, Frank Billings, and Orrin N. Carter.

The Mexican Disinfectant company, Carrollton; capital, \$5,000; manufacturing disinfectants; incorporators, George S. Chism, A. B. Eldred, and John E. Chism.

The Empire Pharmacal company, Chicago; capital, \$2,500; manufacturing medicines; incorporators, Herbert B. Semmelmeier, Fred D. Jackson, and George N. B. Lowes.

The Columbus Laboratories, First Academy of Compounders and Distillers, Chicago; capital, \$1,000; educational, incorporators, John E. Wesner, Charles Norton, and Adolph Gerhman.

The Ithuriel university, Chicago; capital, \$15,000; educational; incorporators, Mrs. K. V. Grinnell, Mrs. E. L. Bickerdike, and G. D. Bentley.

Old People's Rest Home, Chicago; for benevolent purposes, no capital stock; incorporators, Samuel K. Cheseboro, Burton R. Jones, and Thomas B. Arnold.

The Gardner Disinfecting and Antiseptic Appliance company, Chicago; capital, \$100,000; manufacturing; incorporators, C. E. Hawkins, Frederick Gardner, and Florence King.

The Eyelin company, Chicago; capital, \$2,500; manufacturing proprietary articles and medicines; incorporators, William E. Fitzgerald, Edgar Theriault, and Thomas W. Brown.

The Astropathic institute, Chicago; capital, \$2,500; teaching the science of astrology and horoscopy; incorporators, N. E. George, William F. Cornell, and E. Beckman.

Deaconess Home and Hospital, Peoria, certified to increase in the number of trustees from eleven to twenty-five.

The Good Hope Remedies company, Chicago; capital, \$2,500; manufacturing medicines; incorporators, Otto P. Kalvelage, John M. Schmitz, and Nicholas J. Schmitz.

Greenburg Fur Chest Protector company, Chicago; capital, \$2,500; manufacturing chest protectors; incorporators, I. C. Greenburg, Sam. Kulp, Charles D. Stilwell.

Interstate Medical association, Chicago; capital, \$50,000; object, chemists, druggists, and importers; incorporators, Julius A. Johnson, Charles A. Koepke, Howard S. Prescott.

Huston Brothers company, Chicago; capital, \$5,000; object, manufacturing surgical, veterinary, and dental instruments; incorporators, Richard M. Huston, Hedley S. Huston, Joseph S. Huston.

Foreign corporations were licensed, as follows:

Dr. Kane's Electro Medical Specialties, Pierre, S. D.; capital \$250,000; Illinois capital, \$2,500.

### Marriages, Deaths and Changes of Address.

#### MARRIAGES.

Alden R. Denny, M. D., Galesburg to Miss Susan T. Gould, Chicago, Jan. 7, 1903.  
 Richard M. Fletcher, M. D., to Miss Anna Ford Ludlow, Chicago, Feb. 12, 1903.  
 Vaclav Podstata, M. D., Kankakee to Miss Mary G. Porter, Lawton, Okla., Jan. 12, 1903.  
 Wm. O. Powell, M. D., Mackinaw to Mrs. M. Louise Corey, Bloomington, Jan. 21, 1903.  
 John A. Prince, M. D., Springfield to Miss Eva Cross, Mechanicsburg, Jan. 14, 1903.

#### DEATHS.

Ash, John, Brighton, Jan. 31, 1903, aged 84.  
 Conley, P. H., Chicago, Feb. 3, 1903, aged 42.  
 Dawson, J. H., Milton, Jan. 29, 1903, aged —.  
 Graham, John, Plainville, Jan. 23, 1903, aged 65.  
 Hinish, Wm. W., Chicago, Feb. 10, 1903, aged 60.  
 Hood, H. H., Litchfield, Feb. 20, 1903, aged 79.  
 Porter, P. B., Chicago, Feb. 8, 1903, aged 58.  
 Tomboken, Henry, Chicago, Feb. 7, 1903, aged —.  
 Vimond, C. W., Chicago, Feb. —, 1903, aged 38.  
 Xelowski, J. H., Decatur, Jan. 16, 1903, aged 27.

#### CHANGES OF ADDRESS.

##### CHANGES IN CHICAGO.

Acres, L., 960 Jackson Bd., to 968 Monroe st.  
 Allen, F. M., 331-41st st., to 4059 Prairie ave.  
 Abell, Nathan W., 1753 Milwaukee ave., to 1242 N. California ave.  
 Carroll, J. M., 576 LaSalle ave., to 243 N. Clark st.  
 Elliot, A. R., Auditorium Hotel to 138 Lincoln Park Boulevard.  
 Farnowsky, D., to 34 Washington st.  
 Hollenbeck, F. D., 205 N. State st., to 183 Rush st.  
 Hexton, L., 1276 Adams st., to 175 Park ave.  
 Herrick, J. B., 751 Warren ave., to 200 Ashland ave.  
 Monelsdorf, A., 438 Lincoln ave., to 1338 Sheffield ave.  
 Pfeifer, Josephine D., to Lexington Hotel.  
 Saurenhaus, E., to 47 Bellevue Place.  
 Stewart, W. C., 1621 W. 21st st., to 35 Randolph st.  
 Tice, Frederick, to 1496 W. Madison st.  
 Wood, A., 143-35th st., to 4238 Vincennes ave.  
 Wood, G., 143-35th st., to 4238 Vincennes ave.

##### CHANGES FROM CHICAGO.

Bennett, E. R., 1107 Montana, to 1320 Lawrence ave., Edgewater, Ill.  
 Dolan, A. M. J., to Aberdeen, S. D.  
 Fox, C. P., to Milton, Wis.  
 Neely, J. R., 1325 Sheffield ave., to Dunning, Ill.  
 Ross, J. L., to Oakland, Cal.  
 Wells, Francis P., 883 Monroe st., to New York City.

##### CHANGES TO CHICAGO.

Bowier, C., Rockford to Table Rock, Neb.  
 Stewart, G. N., Cleveland to University of Chicago.

##### CHANGES FROM ILLINOIS.

Park, Thomas, Carlinville to Seattle, Wash.  
 Parke, C. R., Bloomington to Louisville, Ky.

Pitzer, Geo. C., Henry to State of Kansas.  
 Stout, J. C., to Oakland, Cal.

##### CHANGES IN ILLINOIS.

Baird, J. H., Polo to Sterling.  
 Bowman, P. N., Altona to Virginia.  
 Burkhart, Hada, Rock Island to Springfield.  
 Burkhart, James R., Rock Island to Springfield.  
 Calhoun, G. O., Tallula to Farmingdale.  
 Cowan, G. R., Girard to 309 Union st., Joliet.  
 Dick, J. H., Waynesville to Minier.  
 Holke, H. T., Clarksdale to Tallula.  
 Rigg, John J., Quincy to Mt. Pulaski.  
 Spicer, C. R., Taylorville to Springfield.  
 Vernon, G. H., Farmingdale to E. St. Louis.

##### CHANGES TO ILLINOIS.

Drury, H. N., Joplin, Mo., to Welton.  
 Molz, Chas., Lawrence Co. Indiana to Pana.  
 Thresh, J. N., Jericho, Mo., to Beecher City.

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2. Their uniformity of effect.
3. Their certainty of effect.
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8. The perfection with which their action has been worked out allows really scientific application.
9. They do not deteriorate with age or in any climate, are easy to use, pleasant, safe and sure.
10. They give effects impossible to obtain from the old preparations.
11. Anyone of ordinary intelligence can be taught how to give them and when to stop. Trained nurses while always desirable are not absolutely essential.

Everyone of these statements can be verified by argument or by demonstration. The only question remaining is, whether one is to be ranked on the side of mossy conservatism or of intelligent progress.

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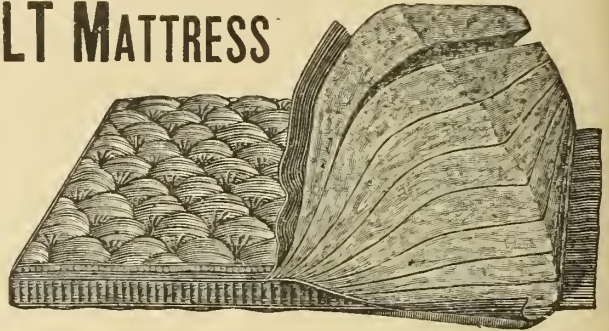
traction of vessels in the inflamed area of lung tissue. Such governing action prohibits extension of the products of inflammation through infiltration by effecting rapid absorption and elimination of toxins. The infected area becomes self-limited as the adjacent blood-vessels supply well-aerated blood to compensate for the surcharged venous blood due to pulmonic consolidation. Under reflex control Antiphlogistine resolves hepatization of lung tissue and through osmosis and dialysis assists the superficial blood-vessels and lymph spaces to drain the hyperaemic parts by direct capillarity. Lessened blood-pressure prevents administration of whipping medication to the over-burdened heart.

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FOR  
PARTICULARS  
ADDRESS

**ORPHEUS EUERTS, M. D., Supt., College Hill Station, Cincinnati, Ohio.**



# Supplement to the ILLINOIS MEDICAL JOURNAL, March, 1903.

TEXT OF THE BILL WHICH WILL BE INTRODUCED MARCH 3, 1903, having for its object the creation of a State Board of Medical Examiners, and to regulate the practice of medicine in the State of Illinois. This bill has been revised and has the approval of the Hon. S. P. Shope, Ex-Chief Justice of the Supreme Court; Hon. Warwick A. Shaw, of Chicago, Attorney of the Illinois State Board of Health, and the Hon. Edward P. Kirby, a leading jurist of Central Illinois. It retains all the good features of the present law, but in a more perfect form. All schools are guaranteed representation, which for the sectarian schools and osteopaths is an improvement on the present law.

A bill for an act to regulate the practice of Medicine in the State of Illinois and for the repeal of all other Acts named herein in relation to said subject.

Section 1. BOARD OF MEDICAL EXAMINERS CREATED. Be it enacted by the People of the State of Illinois, represented in the General Assembly:

That there is hereby created and established a Board of Seven members, which shall be known as The Board of Medical Examiners of the State of Illinois, who shall be appointed by the Governor, with the advice and consent of the Senate.

Section 2. NOMINATIONS. The members of said Board shall be appointed from persons nominated by the incorporated State Medical Societies of the State of Illinois: Provided, the number of persons nominated shall be twice the number of appointments to be made. Every incorporated State Medical Society of Illinois, having an actual membership of not less than One Hundred resident licentiates in medicine and surgery, and embracing an actual membership from at least Twenty (20) counties in the State of Illinois, may submit to the Governor nominations for membership in said Board.

Section 3. APPOINTMENTS FROM EACH MEDICAL SOCIETY. The Governor shall appoint at least one member of said Board from each of said State Medical societies making nominations for membership in said Board, unless such State Medical Societies shall exceed seven in number.

Section 4. TERMS OF OFFICE. The members of said Board shall serve for seven years, except the members of the first Board, of which one shall be appointed for one year, one for two years, one for three years, one for four years, one for five years, one for six years and one for

seven years, and the successors of the members so appointed shall each serve for a term of seven years.

Section 5. VACANCY IN MEMBERSHIP. If a vacancy in the membership of said Board shall be caused by the death of any member, or by his resignation or removal from the State of Illinois, the Governor shall fill the vacancy so created, for the unexpired term, by appointment from nominations made, as hereinbefore provided for nominations for membership.

Section 6. ORGANIZATION OF BOARD. Said Board shall be organized by electing a President, a Vice-President, a Secretary and a Treasurer, who shall hold their respective positions for one year and until their successors are elected, and an election of such officers shall be held annually after the date of the first organization of the Board.

Section 7. SALARIES AND COMPENSATION. The Secretary shall receive a salary to be fixed by the Board, and also his necessary expenses in performing his official duties. The other members of the Board shall receive not to exceed Ten (\$10) Dollars per day for the time actually employed in the discharge of their official duties, and also their necessary expenses while engaged therein. Said salaries and expenses shall be paid from the fees received by the Board, under the provisions of this Act.

Section 8. BOND OF TREASURER. The Treasurer shall give a bond in the sum of Five Thousand (\$5,000) Dollars, with sureties approved by the Board, conditioned on the faithful discharge of his duties, as Treasurer, and a proper accounting for all moneys received by him.

Section 9. POWERS OF THE BOARD. Said Board of Medical Examiners shall have power to formulate all rules necessary to govern its actions; adopt an official seal;

take testimony and procure evidence in all matters relating to its duties; prosecute all persons violating the provisions of this act; prosecute and defend all actions by or against the State Board of Health, under "An Act to Regulate the Practice of Medicine in the State of Illinois and to Repeal an Act Therein Named," approved April 24th, 1899, and in force July 1, 1899, and the President and Secretary of said Board shall each have power to administer oaths. Said Board shall also appoint times and places for meetings, and for examination of applicants, and due notice of such meetings and examinations shall be given by publication.

Section 10. RECORD OF PROCEEDINGS. The Board shall keep an official record of its proceedings, including a register of the names of all applicants for certificates under this Act, and of the action of the Board thereon; such record shall be open to public inspection at all times and shall be published quarterly by said Board; provided that this Section shall not be construed so as to require said Board to record or make public confidential communications.

Section 11. DEFINITION. Any person shall be regarded as practicing medicine within the meaning of this act, who shall treat or profess to treat, operate on or prescribe for any physical ailment or any physical injury to, or deformity of another; provided, that nothing in this section shall be construed to apply to the administration of domestic or family remedies in cases of emergency, or to the laws regulating the practice of dentistry or of pharmacy. And this act shall not apply to surgeons of the United States Army, Navy or Public Health and Marine Hospital service in the discharge of their official duties.

Section 12. REQUIREMENTS. No person, unless previously registered and legally authorized, as defined by this Act, shall practice medicine and surgery, or engage in the restricted practice of medicine as herein defined, or practice midwifery, in the State of Illinois, after

the first day of October, 1903, without first applying for, securing and filing for record a certificate from the State Board of Medical Examiners, as herein provided.

Such certificate, when duly filed for record with the County Clerk, shall constitute a license to the person therein named, to practice medicine and surgery or the restricted practice of medicine, or midwifery, as the case may be, in the State of Illinois, during his or her good behavior in said practice, and to demand and receive fees for any services which he or she may render in this State. The provisions of this Act shall apply to any certificate or license, issued by said Board of Medical Examiners, or by the State Board of Health, either under an Act to regulate the practice of medicine and surgery and to repeal an Act named therein, approved April 24, 1899, in force July 1, 1899, or under an Act to regulate the practice of medicine in the State of Illinois, approved June 16, 1887, in force July 1, 1887, or under an Act to regulate the practice of medicine in the State of Illinois, approved May 29, 1877, and in force July 1, 1877. All such certificates may be withheld or revoked by said Board of Medical Examiners, after due notice and opportunity for a hearing, but only because of immoral practices affecting his professional standing or unprofessional conduct on the part of the person to whom such license is issued, and such notice shall be in writing and be served, upon the person, charged with unprofessional conduct, at least thirty days prior to the hearing of the case; which notice shall be signed by the Secretary of the State Board of Medical Examiners and sealed with the seal of the Board, and if upon hearing, the charges shall be sustained, the said certificate or license of such person may be withheld or revoked by the State Board of Medical Examiners.

Provided, that those persons who are authorized to engage in other

systems or sciences of the treatment of human ailments, known in this Act as the restricted practice of medicine, shall not use any drug or appliance, internally or externally, or perform any surgical operation, or practice midwifery.

Provided, that those persons who are authorized to practice midwifery only, shall not attend any other than cases of labor, nor use any drug, medicine, mechanical device or articles of material substance, except such antiseptics as may be necessary.

**Section 13. APPLICATIONS—MEDICINE AND SURGERY.** Any person who desires to practice medicine and surgery shall file with the Secretary of the Board his diploma or license, and a regular application in writing on a form to be prescribed by said Board, verified by oath, and accompanied by the fees herein specified, and shall also furnish satisfactory proof that the applicant is twenty-one years of age, and is of good moral character, and has received a sufficient preliminary education, such as may be determined by the Board, and that he has the degree of Doctor of Medicine granted by some legally chartered Medical College or Institution, in good standing, as may be determined by said Board. Such applicant must file with such diploma or license, an affidavit stating that he or she is the lawful possessor of the same and the person named therein and that such diploma or license was procured in a regular course of instruction, or examination, without fraud or misrepresentation of any kind.

The Board may, in its discretion, require evidence in addition to such affidavit, as to any of the matters embraced in such affidavit.

**Section 14. APPLICATIONS—RESTRICTED PRACTICE OF MEDICINE.** Any person who desires to engage in the restricted practice of medicine without using any drug or appliance, internally or externally, or performing any surgical operation, or attending cases of labor, shall file with the Secretary

of said Board a regular application, on a form prescribed by the Board, verified by oath and accompanied by the fee herein specified, and shall also furnish satisfactory proof that the applicant is twenty-one years of age, is of good moral character, has received a sufficient preliminary education, such as may be determined by the Board, and has devoted a sufficient period of time to a systematic study of the organs and functions of the human body, as may be determined by the Board.

**Section 15. APPLICATIONS—MIDWIFERY.** Any person who desires to practice midwifery only, shall file with the Secretary of the Board a regular application, on a form prescribed by the Board, verified by oath and accompanied by the fees herein specified, and shall furnish satisfactory proof that the applicant is twenty-one years of age, is of good moral character, has received a sufficient preliminary education, as may be determined by the Board, and has a diploma from a College or School of Midwifery, in good standing.

**Section 16. EXAMINATION FEES.** Fees for examinations and for certificates, shall be as follows:

For examination in medicine and surgery, Twenty Dollars (\$20), and Five Dollars (\$5) in addition, for certificate, if issued.

For examination in the restricted practice of medicine, Fifteen (\$15) Dollars, and Five (\$5) Dollars in addition, for certificate, if issued.

For examination in mid-wifery, Ten Dollars (\$10), and Five Dollars (\$5) in addition, for certificate, if issued.

All such fees shall be paid by the applicant to the Secretary of the Board, and by said Secretary to the Treasurer of said Board.

**Section 17. EXAMINATIONS.** Any person who shall present to the Board satisfactory credentials in accordance with the rules prescribed by the Board, and has paid the examination fees herein provided for, shall be admitted to an examination. The examinations of



those who desire to practice medicine and surgery, shall be on the following subjects: Anatomy, Physiology, Pathology, Bacteriology, Chemistry and Toxicology, the Cause, Origin and Diagnosis of Disease, Surgery, Obstetrics, Hygiene and Sanitary Science. Provided, that the Board may, in its discretion, accept as the equivalent of an examination in any part of the subjects so required, satisfactory evidence of ten or more years of reputable practice of medicine and surgery since graduation, and provided further that such substitution shall be specified in the certificate herein provided for.

The examination of those who desire to engage in the restricted practice of medicine without the use of any drug, medicine or appliance, internally or externally, and who do not desire to practice operative surgery, or midwifery, shall be on the following subjects: Anatomy, Physiology, Chemistry, the Diagnosis of Disease and Hygiene; provided, that in order to test their knowledge of the treatment proposed to be used by them in their practice, such applicants shall also be examined upon such other subjects as may be submitted by the Special Examining Committee herein provided for.

The examination of those who desire to practice mid-wifery only shall be of such a character as to determine the fitness of the applicant to practice mid-wifery only, as may be determined by the Board.

**Section 18. EXAMINING COMMITTEE—RESTRICTED MEDICINE.** The Governor shall appoint a special committee of three from persons nominated by the incorporated State Associations of those engaged in the restricted practice of medicine in the State of Illinois having an actual membership of at least One Hundred resident members and embracing a membership from at least Twenty counties in this State.

**Section 19. DUTIES OF SPECIAL EXAMINING COMMITTEE.** Said special examining committee shall, at such times as may be designated by the Board, examine the applicant and make report thereof with their conclusions to the

Board for final action on such applicant.

**Section 20. TERMS AND COMPENSATION OF EXAMINING COMMITTEES.** The members of the special examining committee, hereinbefore provided for, shall serve for a term of three (3) years, and on the first committee one shall be appointed for one (1) year, one for two (2) years, and one for three (3) years, and the successor of each for a term of three (3) years. Said committees shall receive, as compensation for their services, a fee of Five (\$5) Dollars for each candidate examined, to be paid by the Treasurer of said Board, from fees received from applicants.

**Section 21. CERTIFICATE TO BE RECORDED.** Every person holding a certificate from the said Board of Medical Examiners shall have it recorded within three months from its date, in the office of the County Clerk of the County in which he resides, and said Clerk shall endorse thereon the date of the recording, and shall immediately notify the Secretary of said Board of the recording of such certificate, and the holder of such certificate shall pay to said Clerk a fee of fifty cents (50c.) for the recording of such certificate and reporting the recording thereof.

**Section 22. COUNTY CLERK'S INDEX.** The County Clerk shall keep a complete index of the certificates recorded and reported by him, with the date of recording and reporting, and his record of certificates shall be open to public inspection during his office hours.

**Section 23. REMOVAL TO ANOTHER COUNTY.** Any person removing to another county to practice shall record his certificate in like manner in the county to which he may remove, and the holder of such certificate shall pay to the County Clerk a fee of Fifty (50) Cents for recording and reporting the same.

**Section 24. PREVIOUS REGISTRATION.** Any person who holds an unrevoked certificate lawfully obtained from the State Board of Health in this state, heretofore existing under the provisions of an Act, entitled "An Act to create and establish a State Board of Health in

the State of Illinois," approved May 28, 1877, and in force July 1, 1877, or under an Act, entitled "An Act to regulate the Practice of Medicine in the State of Illinois," approved May 29, 1877, and in force July 1, 1877, or under an Act, entitled "An Act to regulate the practice of medicine in the State of Illinois," approved June 16, 1887, and in force July 1, 1887, or under the provisions of an Act entitled "An Act to regulate the practice of medicine in the State of Illinois, and to repeal an Act therein named," approved April 24, 1899, and in force July 1, 1899, shall be entitled to practice medicine and surgery, or mid-wifery or other system of treating human ailments, as the case may be, in this State, in the same manner and to the same extent as if his certificate had been issued under this Act, but all such certificates may be revoked for unprofessional conduct, in the same manner and upon the same grounds as if they had been issued under this Act.

**Section 25. CERTIFICATES OF OTHER BOARDS.** Said Board may, in its discretion, formulate and publish rules by which, upon receipt of the examination fees, but without examination of the applicant, issue its certificate to the holder of any certificate or license which shall have been issued to him by the Medical Examining Board of the District of Columbia, or of the United States Army, or the United States Navy, or of the United States Public Health and Marine Hospital Service, or by the examining or licensing Board of any State or Territory of the United States provided, that the professional learning required as the basis for such certificate or license, together with the practice of the applicant thereunder, if any, in the opinion of the Board qualifies the applicant for admission to practice in this State.

**Section 26. PRACTICING WITHOUT A LICENSE.** Any person practicing medicine or surgery or the restricted practice of medicine or mid-wifery as the case may be, in this State without a certificate issued by this Board in compliance with the provisions of this Act, or any person violating the provi-

sions of or performing any of the acts forbidden in and by any section of this Act wherein there is no specific penalty provided in the section so violated shall, for each and every such offense forfeit and pay to the People of the State of Illinois, for the use of the State Board Medical Examiners, the sum of One Hundred Dollars (\$100.00) for the first offense and for the second offense the sum of Two Hundred Dollars (\$200.00) the same to be recovered in an action of debt before any Court of competent jurisdiction.

**Section 27. FRAUDULENT REPRESENTATION OF PRACTITIONERS.** It shall be unlawful for a physician, or any other person, to practice medicine in the State of Illinois under the name of another physician, or to hold himself out as another person, by advertisement, bill, poster or otherwise; or to print or advertise, whether by sign or publication of any kind the name or picture of any other person, real or imaginary, as a physician, at any given place, whether named in the advertisement or not, when there is no such person as advertised, either at the place advertised or within the State of Illinois in the practice of medicine, or where there is no person in existence as advertised.

It shall be unlawful for any person in the State of Illinois, not having a recorded certificate from the said Board of Medical Examiners of Illinois, to act as a representative of or a distributor of medicine for any physician not a resident of the State of Illinois, and any person who shall violate either of the provisions of this section shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be subject to a fine of not less than One Hundred Dollars (\$100.00) nor more than Five Hundred Dollars (\$500.00) for the first offense, and by like fine and by imprisonment for a period of six months in the county jail, in the county in which the offense is committed, for each offense committed thereafter. Provided the provisions of this section shall not apply to pharmacists or others, who in the regular course of business sell pro-

prietary or patent medicines. It shall be the duty of the State's Attorney in each County of Illinois to prosecute all persons violating any provision of this section, in his County.

**Section 28. FORGED CERTIFICATES.** Any person who shall file for record, or attempt to file for record, in the office of the County Clerk of any County in the State of Illinois, as his own the certificate of another, or forge an affidavit of identity, shall be deemed guilty of a felony, and upon conviction thereof, shall be subject to such penalties as are, or may be, imposed under the Statutes of the State of Illinois for the crime of forgery.

**Section 29. FALSE REPRESENTATIONS.** Any person, not duly appointed and fully authorized, assuming to act as a member, or officer, or representative of the State Board of Medical Examiners, shall be deemed guilty of a misdemeanor and shall be punished by a fine of not less than One Hundred Dollars (\$100.00) nor more than Five Hundred Dollars (\$500.00) or by imprisonment in the county jail for a term of not less than Sixty (60) days, nor more than One Hundred and Eighty (180) days, or both such fine and imprisonment. It shall be the duty of the State's Attorney in each county of Illinois to prosecute all persons violating any of the provisions of this section in his County.

**Section 30. ENFORCEMENT OF PENALTIES—APPEALS.** Upon conviction of either of the offenses mentioned in this Act the Court shall as a part of the judgment, order that the defendant be committed to the County Jail of the County until the fines and costs are paid, and upon failure to pay the same immediately, the defendant shall be committed under said order for first offense not more than thirty days and for each subsequent offense not more than ninety days, provided that an endorsement of a part of a fine on the mittimus or record of judgment shall not affect the validity of said mittimus or judgment, or lessen the time of confinement in the county jail, so long as any portion of said fines and costs remain unpaid.

**Section 31. ITINERANT VENDORS—LICENSE.** Any itinerant vendor of any drug, nostrum, ointment or appliance of any kind, intended for the treatment of diseases or injuries, who shall, by writing or printing, or by any other method, profess to the public to cure or treat disease or deformity by the use of any drug, nostrum or application, shall pay a license of One Hundred Dollars (\$100.00) per month into the treasury of said Board, to be collected by the Board in the name of the People of the State of Illinois, for the use of said Board, by an action of debt, in any court of competent jurisdiction. The said Board of Medical Examiners shall issue such license on application made to said Board; such license to be signed by the President and a majority of the members of the Board, and attested by the Secretary, and then authenticated by the official seal of the Board; but said Board may, in its discretion, refuse such license.

Any such itinerant vendor who shall, by writing, printing or other method, profess to cure or treat diseases or deformities, by any drug, nostrum or appliance, not having such license, shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than One Hundred Dollars (\$100.00) nor more than Five Hundred Dollars (\$500.00), or by imprisonment in the county jail for a term of not less than Sixty (60) days, nor more than One Hundred and Eighty (180) days, or by both such fine and imprisonment; provided, however, that nothing in this Section shall be so construed as a permit to an itinerant physician to register and practice medicine in this State.

The words "itinerant vendor" shall be construed to mean for the purposes of this Act any person who shall sell, vend or give away and medicine, drug or device, nostrum or application for the treatment of human ailments, on the streets of any city, town, village or municipality, or who having no regular, permanent place of business shall sell or vend any such medicine, drug or device for the cure of human ailments, or shall use any public place or public hall to vend, sell or give away any such medicine, drug or device for the



treatment of the human ailments of another.

Any such itinerant vendor who shall by writing or printing or any other method profess to cure or treat any disease or deformity by any drug, nostrum or appliance without a license so to do, shall be deemed guilty of a violation of this section and upon conviction shall be subject to the penalties herein provided by this section.

Section 32. FINES. The fines collected in the enforcement of this act shall be for the use of the State Board of Medical Examiners and paid over to the secretary of the State Board of Medical Examiners by the proper legalized authorities collecting the same.

Section 33. BOARD TO MAKE REPORT AND ACCOUNT FOR FUNDS. On the Thirtieth day of September of each year the said Board of Medical Examiners shall make report to the Governor of its proceedings, including a register of all persons licensed to practice medicine and surgery, the restricted practice of medicine, mid-wifery, as the

case may be, in the State of Illinois, in accordance with the provisions of this Act. Said report must show all items of receipts from all sources, and all disbursements for all purposes. All funds in the treasury at that date, exceeding One Thousand (\$1,000), shall be paid into the State Treasury.

Section 34. PAPERS AND PROPERTY TO BE TURNED OVER. Within ten (10) days after the taking effect of this Act all books, papers, records, indexes, correspondence and all other matters or properties in the possession of the Illinois State Board of Health heretofore empowered to regulate the practice of medicine in the State of Illinois, and pertaining to and used by them in the enforcement of the various acts to regulate the practice of medicine in Illinois shall be turned over to the State Board of Medical Examiners, and also all moneys by the said Board of Health in the enforcement of the provisions of the Medical Practice Act and remaining in the Treasury on the 30th day of September, 1903.

## THE LEGISLATIVE LEAGUE OF THE MEDICAL PROFESSION OF ILLINOIS, REPRESENTING NEARLY 2000 PERSONS OF ALL SCHOOLS OF PRACTICE.

Below we give a list of the members of the Legislative League of the Illinois State Medical Society. The members of this league are of two classes. First, the individuals who have contributed one or more dollars for the use of the Legislative Committee, and second the medical societies which have contributed money, from their society treasuries for the use of the Legislative Committee. As is well known, the State Society does not have sufficient funds from its annual dues for the work of the committee, therefore the committee is under the necessity of calling on the members of the profession for contributions. The following list will show the contributions this year. Each physician below has contributed at least \$1.00 for the committee. Many of these belong to societies which have also contributed out of their treasuries as will be seen by the list of contributing societies.

These lists for convenience and future use are arranged by senatorial districts and give the number of the districts, its boundary, the name of each county society in the district with the name of the President and Secretary, the name and address of its senator and representatives with their politics, and the name and address of each member of the league living in that district and the name and amount subscribed by societies out of their treasuries. We think this arrangement will be of great assistance to our members.

The Legislative Committee especially request that each member of the profession look this list over carefully and notify the chairman of any errors.

They would especially like to be notified if the name of anyone who has contributed and has been omitted from the list, or is not given in the proper district. We trust that our readers will make this list a matter of personal interest and advise the committee at once of any corrections which should be made in it, and also interest other physicians in the work and secure their moral as well as their financial support. The Legislative Committee will require all the funds that can possibly be raised for the work of this winter.

In addition to this list the Chairman of the Legislative Committee, Dr. Carl E. Black, of Jacksonville, states that 35 local societies, including Chicago Medical Society, have already unanimously endorsed the memoranda for a proposed bill for the regulation of the practice of medicine and establishing a board of medical examiners in the State of Illinois, and have instructed their Legislative Committees to wait upon the members of the Legislature and secure their favorable consideration of the proposed bill.

### CHICAGO.

Senatorial Districts: 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 13, 15, 17, 19, 21, 23, 25, 27, 29 and 31.  
Chicago Medical Society, President—W. A. Evans, 103 State street. Secretary F. X. Walls, 103 State street.

Physicians Legislative League, Chairman, R. B. Preble, 103 State street. Secretary—Arthur M. Corwin, 34 Washington street. Member of the Legislative Committee of Illinois State Society, E. Fletcher Ingals, 34 Washington street.

### 1ST. DISTRICT.

1st and 2d Wards. Boundaries: East by the Lake; West by river to 22d street, S. Clark from 22d to 28th Princeton avenue from 26th to 32d. North by river.

South by 22d street from river to S. Clark, 32d and 33d street from Princeton avenue East.

Senator—Geo. Wm. Dixon, 3131 Michigan avenue. Republican.

Representatives—Jacob Ball, 2180 Archer street. Republican; Edward H. Morris, 2712 Dearborn street, Republican; S. W. Arrand, 1318 Wabash avenue, Democrat.

### PHYSICIANS OF LEAGUE.

Allport, Frank, 92 State street and 57 E. 20th street.

Barnes, W. S., 3000 Michigan avenue and 107 E. 37th street.

Baum Wm. L., 103 State street.

Bishop, Rufus W., 70 State street and Calumet Club.

Bieringer, R. W., 70 State street.

Braunwarth, Anna M., 3119 South Park and 100 State street.

Burdick, G. G., 126 State street and 2979 S. Park avenue.

Billings, Frank, 100 State street and 35-22d street.

Belfield, Wm. T., 622 Opera House Bldg.

Crutcher, Howard, 100 State street.

Dudley, E. C., 1617 Indiana street.

Edwards, Arthur R., 2818 Indiana avenue.

Evans, W. A., 103 State street.

Faber, P. J., 70 Madison street.

Gilman, J. E., Masonic Temple and 23d and Michigan avenue.

Hammond, J. D., 11 Congress street.

Johnson, Frank S., 2521 Prairie avenue.

Kreisel, F., 92 State street.

Lodor, C. H., 3136 Indiana avenue.

Macmartin, D. R., 77 Jackson Blvd.

McDermid, A., 103 State street.

Mackey, Cornelius, 1200 Wabash avenue.

Merriman, H. P., 2230 Michigan avenue.

Nelson, Daniel T., 2400 Indiana avenue.

Patton, D. H. R., 1558 Wabash avenue.

Pierron, J. J., 353-5th Avenue and 2945 Wabash avenue.

Peterson, H. T., 1800 Michigan avenue.

Quine, Wm. E., 103 State street and 3160 Indiana avenue.

Stilians, D. C., 230 Michigan avenue.

Steele, D. A. K., 2920 Indiana avenue.

Stevenson, Sarah H., 34 Washington street.

Storey, C. A., 52-31st street.

Stowell, J. H., 2633 Indiana avenue.

Tydings, Oliver, 103 State street.

Watkins, Thos. J., 1800 Michigan avenue.

Webster, Geo. W., 70 State street and 1922 Michigan avenue.

Wood, C. A., 103 E. Adams street.

### 2D DISTRICT.

Boundaries: East, Center Avenue from Madison to Van Buren; Loomis from Van Buren, to W. Taylor; Laffin from W. Taylor to 16th West; Western Avenue from Washington Blvd. to 12th California avenue from 12th to 16th street. North, Washington Blvd. and W. Madison; South, 16th street from California to Laffin.

Senator—Wm. I. Riley, 300 The Temple, Republican.

Representatives—Chas. W. Kopf, 503 Ashland Blvd. Republican; Benj. F. Greenebaum, 395 Ashland Blvd., Republican; F. E. Donoghue, 398 W. Adams street, Democrat.

### PHYSICIANS OF LEAGUE.

Baldwin, A. E., 828 W. Adams street.

Barr, W. A., 100 State street and 730 W. Adams.

Bates, M. D. C., 171 Warren avenue.

Brower, D. R., 34 Washington street and 597 Jackson street.

Bryan, J. A., 1079 Washington Blvd.  
 Byrne, Jno. H., 690 W. Monroe street.  
 Corwin, A. M., 722 W. Monroe and 34 Washington streets.  
 Danforth, I. N., 70 State street and 905 W. Monroe.  
 Davenport, Nora S., 207 Warren avenue.  
 Dodson, J. M., 34 Washington street and 568 Washington.  
 Favill, H. B., 100 State street, and 412 E. Ontario street.  
 Foster, A. H., 719 W. Monroe street.  
 Graham, David W., 672 W. Monroe street.  
 Kenyon, E. L., 940 W. Madison street.  
 Moyer, H. M., 103 State street and 434 W. Adams street.  
 Webster, Jno. C., 946 Jackson Blvd.  
 Weaver, Geo. W., 535 Washington Blvd.

**3D DISTRICT.**

Boundaries: N.-W. part bounded East side Princeton avenue and Clark; West South Halsted; North 22d street; South 33d street. Southeast part, East by the Lake; West State from 39 to 43, Farnell and Union from 32 to 39 South; 39 from Farnell to State; 43 from State to the Lake.  
 Senator—Michael E. Maher, 583, 27th street, Democrat.  
 Representatives—Sigmund S. Jones, 346, 37th street, Republican; F. L. Davies, 465 Bowen avenue, Republican; R. E. Corrigan, 3229 Indiana avenue, Democrat.

**PHYSICIANS OF LEAGUE.**

Capps, Jos. R., 100 State street and 35, 22d street.  
 Deming, H. H., 4356 Greenwood avenue.  
 Doering, E. J., 2458 Indiana avenue.  
 DeLee, J. B., 3632 Prairie avenue.  
 Cowen, Guy A., 420 E. 26th street.  
 Harsha, Wm. M., 4201 Grand Blvd.  
 Hawley, Jos. R., 3421 S. Park avenue.  
 Hyde, Jas. N., 100 State street and 2409 Michigan avenue.  
 Johnston, A. R., 4147 Lake avenue.  
 Larned, E. R., 230 Oakwood Blvd.  
 Lodor, C. H., 3136 Indiana avenue.  
 Martin, F. H., 103 State street, and 3210 Lincoln Park avenue.  
 Murphy, J. B., 100 State street and 3305 Michigan avenue.  
 Mix, C. L., 3134 S. Park avenue.  
 Menge, E., 154 E. 42d Place.  
 Mann, W. A., 70 State street.  
 Riles, E., 100 State street, and 3547 Indiana.  
 Sage, Anna W., 100 State street and 17 E. 40th street.  
 Salinger, David, 103 State street and 4047 Grand Schmidt, O. L., Schiller Bldg. and 3328 Michigan avenue.  
 Snow, M., 3914 Ellis avenue.  
 Starkey, H. L., 70 State street and 3300 Indiana avenue.  
 Straus, T. J., 3640 Cottage Grove avenue.  
 Tuteur, E. D., 3645 Grand Blvd.

**4TH DISTRICT.****29th and 30th Wards.**

Boundaries: East by State street; West by 48th street; North by 39th street; South by 55th street.  
 Senator—Michael J. Butler, 5728 State street, Democrat.  
 Representatives—Frank E. Christian, 5313 Bishop street, Republican; Isaac Miller, 4159 Western avenue Blvd., Democrat; Edward M. Cummings, 4439 Lowe avenue, Democrat.

**PHYSICIANS OF LEAGUE.**

Cambourn, Stephen A., 5101 Wentworth avenue.  
 Rose, F. L., 5420 Halsted street.

**5TH DISTRICT.**

Boundaries: East by the Lake from 43d to 63d, Cottage Grove from 63d to 71st; West by State street; North by 43d; South by 63d from Cottage Grove to the Lake; 71st from Cottage Grove to State street.  
 Senator—Francis W. Parker, Hotel Del Prado, Republican.  
 Representatives—Aaron Norden, 4639 Vincennes avenue, Republican; Michael E. Hunt, 5732 Monroe

avenue, Democrat; Oliver W. Stewart, 5538 Cornell avenue, Prohibition.

**PHYSICIANS OF LEAGUE.**

Abt. I. A., 4326 Vincennes avenue.  
 Allport, H. W., 100 State street and Chicago Beach Hotel.  
 Bailey, G. T., 4311 Vincennes avenue.  
 Barker, L. F., University of Chicago.  
 Black, G. V., 4465 Oakwood avenue.  
 Church, Archibald, 4858 Madison avenue.  
 Cheney, Henry V., 369 E. 63d street.  
 Collins, R. G., 5059 Statte street.  
 Cook, J. C., 5708 Rosalie street.  
 Dodds, Robt., 144 Oakwood Blvd.  
 Duncan, Wm. E., 6058 Kimbark avenue.  
 Fischkin, E. A., 4809 Prairie avenue.  
 Fuller, Wm., 134-47th street.  
 Frankenthal, L. E., 109 Randolph street and 4800 Kimbark avenue.  
 Green, Frederick R., 6312 Greenwood avenue.  
 Hoag, J. C., 4669 Lake avenue.  
 Hardie, T. M., 34 Washington street and 5244 Cornell avenue.  
 Hess, J. H., 55th Blvd. Indiana avenue.  
 Ingals, E. Fletcher, 4757 Grand Blvd.  
 Washington avenue.  
 Kuh, Sidney, 4330 Drexel Blvd.  
 Knudson, T. J., 4646 Prairie avenue.  
 Lowe, Julia R., 5756 Kenwood avenue.  
 McArthur, L. L., 4415 Drexel Blvd.  
 Miller, Jos. L., 100 State street and 159 E. 47th street.  
 Montgomery, F. H., 100 State street and 5548 Woodlawn avenue.  
 Mettler, L. H., 100 State street and 4554 Lake avenue.  
 Nance, W. C., 100 State street and 5213 Hibbard avenue.  
 Oughton, Chas. M., 5410 Jefferson avenue.  
 Plummer, S. C., 4304 Lake avenue.  
 Riese, B. L., 215 Wabash avenue and 4312 Vernon avenue.  
 Rittenhouse, H. M., 4739 Rosalie street.  
 Small, Chas. P., 5729 Madison avenue.  
 Smith, J. P., 5500 State street.  
 Soliday, V. R., 5020 Washington avenue.  
 Stewart, E. S., 4624 Indiana avenue.  
 Test, F. C., 4401 Indiana avenue.  
 VanHook, Weller, 103 State street and 5759 Walker, Jas. W., 153 E. 53d street.  
 Whitfield, G. W., 215 Wabash avenue and 5428 Monroe avenue.  
 Wilder, W. H., 103 State street and 5811 Monroe avenue.  
 Wilson, Wm. L., 5654 Monroe avenue.  
 Warbrick, J. C., 47th and Kenwood avenue.  
 Weber, S. L., 199 state street and 4400 Vincennes avenue.  
 Walls, F. X., 4307 Ellis avenue.

**6TH DISTRICT.**

Long and Narrow, North and South, takes in Evanston.

Boundaries: East by the Lake, north of city limits at Devon, North Clark, Racine and Halsted street to North avenue; West by river from North avenue to Belmont to Western avenue from Belmont to Devon and Kedzie north of city limits; South by North avenue and river; northwith boundary of Evanston.

Senator—Thomas J. Dawson, 904 Addison street, Democrat.

Representatives—Harry Oldam, 737 Bureau avenue, Republican; Edward J. Brundage, 259 Seminary avenue, Republican; M. L. McKinley, 2727 N. Robey street, Democrat.

**PHYSICIANS OF LEAGUE.**

Ballenger, Wm. L., Evanston and 100 State street.  
 Germer, Dr., 511 Lincoln avenue.  
 Green, G. W., 1296 Ravenswood Blvd.  
 Howland, E. D., 307 Belden avenue.  
 O'Neil, Jno. W., 1373 North Clark street.  
 Pusey, Brown, 31 Washington street and Evanston.  
 Pusey, W. A., Evanston.  
 Stover, W. D., 485 Fullerton avenue.  
 Whalen, Chas. J., 34 Washington street and 309 Belden avenue.



**7TH DISTRICT.**

Boundary: Outside of city limits.

Senator—John Humphrey, Orland, Republican.  
Representatives—Geo. Struckman, Bartlett, Republican; James W. Turner, LaGrange, Republican; John W. Farley, 7th avenue, LaGrange, Democrat.

**PHYSICIANS OF LEAGUE.**

Roberts, Thomas E., Oak Park.

**8TH DISTRICT.**

Senator—DuFay A. Fuller, Belvidere, Republican.

Representatives—Edward D. Shurtleff, Marengo, Republican; Geo. R. Lyon, 403 Sheridan road, Waukegan, Republican; William Desmond, Woodstock, Democrat.

**9TH DISTRICT.**

Boundaries: East by S. Halsted and Parnell avenue, 22d to 39th; West by Drainage Canal, S. Central Park avenue and C. B. & Q. R. R.; North, Q. R. R. and canal; South by 39th street.

Senator—Edward J. Rainey, 3622 S. Union avenue, Democrat.

Representatives—David E. Shanahan, 1566 35th street, Republican; Anton J. Cermak, 444 W. 25th street, Democrat; Thomas J. Deady, 1117 S. Oakley avenue, Democrat.

**PHYSICIANS OF LEAGUE.**

Abt. J. L., 733 S. Halsted street.  
Hepburn, J. C., 3601 S. Halsted street.

**11TH DISTRICT.**

Boundaries: East State 55th to 49th, Sawyer, Halsted to 107th; West, 48th from 55th to 87th, Western from 87th to 107th; North, 55th; South, 87th west of Western avenue, 107th from Western avenue to Halsted.

Senator—Carl Lundberg, 5949 S. Sangamon street, Republican.

Representatives—Chester W. Church, 9226 Longwood avenue, Republican; Nicholas J. Nagel, 5552 Princeton avenue, Republican; John E. Doyle, 5516 Aberdeen street, Democrat.

**PHYSICIANS OF LEAGUE.**

Boettcher, H. R., 34 Washington street and 6336 Howard street.  
Byrne, W. D., 6901 S. Halsted street and 6526 Perry avenue.

Campbell, J. G., 6857 Wentworth avenue.  
Hagens, G. J., 605 S. Halsted street.  
Hunt, J. S., 440 Englewood avenue.  
Karreman, A. R., 534 63d street.  
MacLellan, Chas., 6921 Wentworth avenue.  
Phillips, C. J., 401 Garfield Blvd.  
Simpson, E. E., 6301 Halsted street.  
Shortle, A. C., 63d and St. Louis avenue.  
Tillotson, H. T., 6301 Wentworth avenue.  
Webster, J. P., 63d and Stewart avenue.

**12TH DISTRICT.**

8th and 33d Wards, Calumet Lake Region.

Boundaries: East by the Lake; West, Cottage Grove from 63d to 71st street, 71st to 89th, Stewart avenue and Halsted, 99th, 107th, Western avenue, 107th to 138th; South, 136th street; North, 63d from Cottage Grove avenue to Lake, 71 Cottage Grove to State, 107th from Halsted to Western.

Senator—Albert C. Clark, 7137 Euclid avenue, Republican.

Representatives—Benton F. Kleeman, 11417 Michigan avenue, Republican; Jas. H. Wilkerson, 6347 Woodlawn avenue, Republican; Henry V. Meeteren, 11365 Michigan avenue, Democrat.

**PHYSICIANS OF LEAGUE.**

Dickson, W. E., 100 State street and Woodlawn avenue.  
Harvey, Don S., 9154 Commercial avenue.  
Nelson, Engelbrecht, 175 E. 92d St.  
Swan, C. F., 9139 Commercial avenue.

**15TH DISTRICT.**

9th, 10th and 11th Wards.

Boundaries: East, the river; West, Hoyne; South, Canal and river; North, Maxwell from 14th to 16th street.

Senator—Cyril R. Jandus, 233 W. 20th street, Democrat.

Representatives—Jas. P. Gavanough, 162 W. 18th street, Republican; Peter Knella, 706 W. 18th street, Democrat; Ladislav J. Fligl, 606 S. Centre street, Democrat.

**PHYSICIANS OF LEAGUE.**

Thometz, J. J., 564 S. Halsted street.

**17TH DISTRICT.**

19th Ward.

Boundaries: East river; West Laflin; South Maxwell; North Van Buren street.

Senator—John Powers, 79 McAllister, Democrat.

Representatives—Edward J. Smajkal, 77 Bunker street, Republican; John Noonan, 307 W. Congress street, Democrat; Clarence S. Darrow, 456 S. Darrow, 456 S. Desplaines street, Public Own.

**PHYSICIANS OF LEAGUE.**

Gfroerer, Geo. F., Center avenue and Taylor street.

Graves, C. H., 616 W. 12th street.

Moyer, H. N., 103 State street and 434 W. Adams street.

Stoll, J. J., 514 W. 12th street.

**19TH DISTRICT**

13th and 14th Wards, Cicero and Riverside.

Boundaries: North Washington from Western to Homan, Kinzie from Homan to 46th; South 39th and C. B. & Q. R. R.; East Western from Washington to 12th, California from 12th to 22d; West 46th.

Senator—Frank C. Farnham, 1064 Wilcox avenue, Republican.

Representatives—August W. Nohe, 947 Clifton Park avenue, Republican; Wm. W. Weare, Morton Park, Republican; Richard E. Burke, 1528 W. Van Buren street, Democrat.

**PHYSICIANS OF LEAGUE.**

Borland, L. C., 685 Ogden avenue and 1168 Douglas Blvd.

Breckenridge, S. L., Riverside.

Cotton, A. C., 1485 Jackson Blvd.

Haywood, C. W., Riverside.

Larken, O. E., 2079 Jackson Blvd.

Nagel, J. S., 323 S. Western avenue.

Phillip, A. N., 3660 Fulton street.

Rhodes, J. E., 147 S. Central Park avenue.

Stewart, H. J., 2118 W. Lake street.

Wescott, C. D., 1609 Adams street.

**21ST DISTRICT.**

Boundaries: East by Milwaukee avenue and Green street; West by Austin avenue; North W. Chicago avenue; South W. 12th street between Austin and 48th avenue, W. Kinzie between 46th and Homan and Washington Blvd. between Homan and Ashland.

Senator—Daniel A. Campbell, 493 W. Erie street, Republican.

Representatives—Frederick E. Erickson, 256 N. Carpenter street, Republican; Benjamin M. Mitchell, 1314 Fulton street, Democrat; John J. McMannan, 1029 W. Superior street, Pub. Own.

**PHYSICIANS OF LEAGUE.**

Bouffleur, A. I., 1159 Washington Blvd.

Colwell, N. P., 161 N. Carpenter street.

Lee, J. K., 116 N. Center street

Parker, Chas. A., 18 S. Huron avenue.

Pendergast, Jas., 1510 Lake street.

Tagert, A. H., 966 W. Lake street.

Twining, S. D., 779 Walnut street.

Young, J. E., 71 Park avenue.

**23D DISTRICT.**

15th and 35th Wards.

Boundaries: East by Ashland avenue; West by 72d street; North by North avenue; South by Chicago avenue.

Senator—Niels Juul, 433 Potomac avenue, Republican

Representatives—Henry A. Austin, 217 Lake street, Republican; Abel Davis, 14 Fowler street, Republican; John C. Clark, 2327 Grand avenue, Democrat.

**PHYSICIANS OF LEAGUE.**

Behrendt, Arthur A., 93 Fowler street.

Brown, Herman H., 103 State street and 833 N. Park avenue.

Daniels, Ralph P., 545 N. Leavitt street.

Dahl, S., 622 N. Hoyne avenue.

Dal, John W., 499 N. Robey street.

Goetz, F. A., 1218 Milwaukee avenue.

Rosenberry, A. J., 151 Lake street and Oak Park.

Rowan, C. F., 740 W. North avenue.

Sandberg, Karl, 684 N. California avenue.

**25TH DISTRICT.**  
27th and 28th Wards.

Boundaries: East by N. Western avenue, river and Robey street; West by limits. 72d street; North by limits, W. Devon street; South by W. North avenue.

Senator—Joseph F. Hass, 503 W. Fullerton avenue, Republican.

Representatives—Robert E. Pendarvis, 1537 N. 71st Ct., Republican; Herman H. Breidt, 2710 Milwaukee avenue, Republican; Frank H. Landmesser, 84 Hamburg street, Democrat.

**PHYSICIANS OF LEAGUE.**

Luken, M. H., 587 W. North avenue.  
Wagner, Henry E., 551 Armitage avenue.  
Becker, E. C., 385 W. Diversey avenue.

**27TH DISTRICT.**  
16th and 18th Wards.

Boundaries: East and North to Fullerton avenue by N. Branch of Chicago River; South by W. Van Buren street; West by Center avenue between Van Buren and Madison, Ashland from Madison to Kinzie, Green and Milwaukee avenue from Kinzie to Cornelia, Ashland from Augusta to North avenue and Robey from North avenue to Fullerton.

Senator—Stanley H. Kunz, 685 Noble street, Republican.

Representatives—Albert Glade, 9 N. Curtis street, Republican; Joseph S. Geshkewich, 674 Milwaukee avenue, Democrat; Daniel V. McDonough, 84 S. Central avenue, Democrat.

**PHYSICIANS OF LEAGUE.**

Handshaw, Anna Morgan, 91 Ashland Bldg. and Madison and Ashland avenue.  
Kalacinski, F., 638 Noble street.  
Root, Eliza H., 489 Monroe street.

**29TH DISTRICT.**  
21st and 22d Wards.

Boundaries: East by the Lake; West by the River and N. Halsted street; North by Schiller, Goethe and Division streets; South by the River.

Senator—Harry G. Hall, 181 Superior street, Republican.

Representatives—Samuel E. Erickson, 51 Locust street, Republican; Bernard F. Clettenberg, 126 Larrabee street, Republican; M. B. McNulty, 151 Sedwick street, Democrat.

**PHYSICIANS OF LEAGUE.**

Babcock, Robt. H., 466 Dearborn avenue and 103 State street.  
Banga, Henry 456 LaSalle street.  
Brill, J. A., 428 Milwaukee avenue.  
Bullerman, Wm. P., 523 Garfield avenue.  
Churchill, E. S., 394 E. Chicago avenue.  
Davis, N. S., Sr., 65 Randolph street and 291 E. Huron street.  
Davis, N. S. Jr., 65 Randolph street.  
Favill, Henry B., 100 State street and 412 Ontario street.  
Friedrich, L. H., 279 Claybourn avenue.  
Frick, Anders, 366 E. Division street.  
Gardiner, E. J., 34 Washington street.  
Harris, M. L., 100 State street and 523 LaSalle street.  
Herzog, Marmillian, 174 E. Chicago avenue.  
Hotz, F. C., 34 Washington street and 488 Dearborn avenue.  
Kerr, Norman, 285 LaSalle street and 100 State street.  
Lagorio, A., 228 Dearborn avenue.  
Marquis, Geo P., 394 N. State street and 100 State street.  
Mahoney, G. W., 100 State street and 188 N. State street.  
Neale, R. A., 417 LaSalle avenue.  
Newman, H. P., 438 LaSalle avenue.  
Patrick, Hugh T., 34 Washington street and 463 LaSalle avenue.  
Stephenson, Dr., 103-109 Dearborn avenue.  
Swenson, Carl G., 318 E. Division street.  
Schmidt, L. E., 424 N. State street and Schiller Bldg.  
Talbot, Euene S., 103 State street and 198 Goethe street.  
Wenzlick, Wm., 813 E. Chicago avenue.

**31ST DISTRICT.**  
23d and 25th Wards.

Boundaries: East by the Lake; West by N. Clark street, Racine, Halsted and River; North by Devon avenue, limits; South by Schiller, Goethe, Division and River.

Senator—Carl Mueller, 805 Burling street, Republican.

Representatives—Henry C. Beitler, 16 Lincoln avenue, Republican; Joseph M. Patterson, 166 Astor street, Republican; John C. Wordell, 82 Mohawk street, Democrat.

**PHYSICIANS OF LEAGUE.**

Bacon, C. S., 426 Center street.  
Bacon, J. B., 1216 Diversey Blvd.  
Baxter, Geo E., 1916 Evanston avenue.  
Brown, James M., 34 Washington street.  
Christopher, W. S., 508 Dearborn avenue.  
Doherty, David J., 582 LaSalle avenue.  
Fisher, J. C., 489 Belden avenue.  
Frank, Jacob, 17 Lincoln avenue.  
Goldspohn, A., 519 Cleveland avenue.  
Gray, Ethan A., 160 Evanston avenue.  
Gregory, L. L., 514 Evanston avenue.  
Hartung, Henry, 596 Sheffield avenue.  
Hawley, Geo., 1718 Kenmore avenue.  
Hequembourg, J. E., 512 Fullerton avenue.  
Herz, Carl, 396 Center street.  
Hessert, Wm., 685 Fullerton avenue.  
Jackson, Josephine, 516 Fullerton avenue.  
Kunz, Sylvan, 420 Center street.  
Ochsner, A. J., 710 Sedgwick street.  
Ochsner, Edward H., 710 Sedgwick street.  
Patton, J. A., 103 State street and 1150 Sheridan road.  
Porter, F. D., 1594 N. Halsted street.  
Pennington, J. R., 103 State street.  
Rutherford, Clarendon, 646 Fullerton avenue.  
Senn, E. J., 532 Dearborn avenue.  
Senn, N., 532 Dearborn street.  
Simmons, Geo. N., 103 Dearborn avenue and 1672 Kenmore avenue.  
Williams, Jno. F., 427 Center street.  
Williamson, Chas. S., 491 Dearborn avenue.

**8TH DISTRICT.**

Counties—Boone, McHenry and Lake.

Senator—DuFay A. Fuller, Belvidere, Republican.

Representatives—William Desmond, Woodstock, Democrat; Geo. R. Lyon, 403 Sheridan road, Waukegan, Republican; Edward D. Shurtleff, Marengo, Republican.

**County Societies.**

Lake—President, L. H. Tombough, Waukegan; Secretary, A. C. Haven, Lake Forest.

**Individual Contributions.**

E. H. Ames, Antioch.  
A. E. Brown, Waukegan.  
J. M. G. Carter, Waukegan.  
J. C. Foley, Waukegan.  
E. F. Gavin, Waukegan.  
B. W. Parmenter, Lake Forest.  
J. L. Taylor, Libertyville.  
Elva Wright, Lake Forest.

McHenry—County unorganized.

**Individual Contributions.**

E. V. Anderson, Woodstock.  
W. A. Nason, Algonquin.  
Boone—Unorganized.

**10TH DISTRICT.**

Counties—Ogle and Winnebago.

Senator—Henry Andrus, Rockford, Republican.

Representatives—James J. Wilson, Woosung, Democrat; Johnson, Lawrence, Polo, Republican; Frederick Haines, 628 E. State street, Rockford, Republican.

**County Societies.**

Ogle—President, G. H. McHenry, Oregon; Secretary, H. A. Mix, Oregon.

**Individual Contributions.**

W. W. Burns, Polo.  
W. K. Farley, Oregon.  
Josiah T. Kretsinger, Leaf River.  
H. A. Mix, Oregon.  
G. H. McKenney, Oregon.

Winnebago—President, T. N. Miller, Rockford; Secretary, S. R. Catlin, Rockford.



**Individual Contributions.**

J. E. Allaben, Rockford.  
F. H. Culhane, Rockford.  
W. R. Fringer, Rockford.  
Albert Green, Rockford.  
W. B. Helm, Rockford.  
David B. Penniman, Argyle.  
Penn W. Ransom, Rockford.

**12TH DISTRICT.**

**Counties—**Jo Daviess, Stephenson and Carroll.

**Senator—**John C. McKenzie, Elizabeth, Republican.

**Representatives—**Douglas Pattison, 58 Hardin street, Freeport, Democrat; W. W. Gillespie, Mt. Carroll, Republican; James E. Taggart, Ridott, Republican.

**County Societies.**

**Carroll—**President, J. Haller, Lanark; Secretary, H. S. Metcalf, Mt. Carroll.

**Jo Daviess—**President, H. T. Godfrey, Galena; Secretary, D. G. Smith, Elizabeth.

**Individual Contribution.**

A. C. Czibulka, Warren.  
T. M. Eade, Stockton.  
J. C. Egan, Hanover.  
H. F. Gunn, Galena.  
Wm. Hutton, Elizabeth.  
C. S. E. Lewis, Dubuque.  
A. C. Philips, Apple River.  
I. C. Smith, Stockton.  
C. E. Wright, Scales Mound.

**Stephenson—**President, J. F. Fair, Lena; Secretary, R. J. Burns, Freeport.  
F. J. Holke, Freeport.  
S. J. Kreider, Lena.  
W. J. Rideout, Freeport.  
J. M. Sharp, Stockton.  
D. G. Smith, Elizabeth.  
T. J. Stafford, Stockton.  
J. H. Stealey, Freeport.

**14TH DISTRICT.**

**Counties—**Kane and Kendall.

**Senator—**Henry H. Evans, Aurora, Republican.

**Representatives—**Jno. W. Linden, 220 Grove street, Aurora, Democrat; Chas. T. Cherry, Oswego, Republican; Chas. H. Backus, Hampshire, Republican.

**County Societies.**

**Kendall—**President, Wm. M. Hanna, Lisbon; Secretary, R. A. McClelland, Yorkville.

**Individual Contributor.**

J. A. Freeman, Millington.  
R. A. McClelland, Yorkville.

**Kane—**President, G. J. Schneider, Elgin; Secretary, F. H. Jenks, Aurora.

**Individual Contributors.**

E. H. Abbott, Elgin.  
Geo. F. Allen, Aurora.  
J. F. Bell, Elgin.  
H. A. Brennecke, Aurora.  
S. P. Brown, Elgin.  
E. F. X. Cleveland, Dundee.  
H. T. Hardy, Kaneville.  
G. J. Schneider, Elgin.  
F. W. Nash, Big Rock.

**16TH DISTRICT.**

**Counties—**Putnam, Marshall, Woodford and Livingston.

**Senator—**Robert Boal Fort, Lacon, Republican.

**Representatives—**John P. Moran, Fairbury, Democrat; Josiah Kerrick, Minonk, Republican; Ira M. Lish, Republican.

**County Societies.**

**Livingston—**President, Otis M. Newton, Fairbury; Secretary, Jno. Ross, Pontiac.

**Individual Contributors.**

H. F. Ballard, Chenoa.  
Geo. F. Carson, Chatsworth.  
T. W. Jones, Cornell.  
E. E. Perisho, Ancona.  
W. L. Rabe, Dwight.  
Jno. D. Scouler, Pontiac.

**Marshall—**President, E. S. Everett, Lacon; Secretary, W. G. DuFour, Speer.

**Individual Contributors.**

Robert Boal, Lacon.  
A. W. Bradford, Sparland.  
J. A. Marshall, Pontiac.  
L. G. Thompson, Lacon.

**Woodford—**President, Dr Mendenhall, ———; Secretary, Frank Stubblefield, El Paso.

**Individual Contributors.**

N. B. Crawford, Eureka.  
W. O. Ensign, Rutland.  
J. I. Knoblanck, Metamora.  
Harley A. Zinzer, Roanoke.

**Putnam—**Unorganized.

**18TH DISTRICT.**

**County—**Peoria.

**Senator—**James D. Putnam, Elmwood, Republican.

**Representatives—**Jefferson R. Boulware, 212 Perry avenue, Peoria, Democrat; Chas. F. Black, Mapleton, Republican; Wm. G. McRoberts, 609 McClure street, Peoria, Republican.

**County Societies.**

**Peoria City Medical Society—**President, M. S. Marcy, Peoria; Secretary, E. M. Eckard, Peoria. Society subscription, \$25.00.

**Individual Contributors.**

J. L. Brown, Peoria.  
A. F. Burnham, Peoria.  
A. L. Cocoran, Peoria.  
P. Dombrowski, Peoria.  
Franz Gerzema, Peoria.  
J. W. Hensley, Peoria.  
A. A. Knapp, Brimfield.  
J. A. Plummer, Trivoli.  
Jos. Studer, Peoria.  
H. H. Whitten, Peoria.  
O. B. Will, Peoria.

**20TH DISTRICT.**

**Counties—**Grundy, Kankakee and Iroquois.

**Senator—**Len Small, Kankakee, Republican.

**Representatives—**W. W. Parish, Jr., Mornence, Democrat; Horace Russel, Milford, Republican; Edward C. Curtis, Grant Park, Republican.

**County Societies.**

**Grundy—**President, O. P. Bennett, Mazon; Secretary, H. M. Ferguson, Morris.

**Individual Contributor.**

J. E. Brock, Coal City.

**Kankakee—**President, Chas. True, Kankakee; Secretary, J. A. Brown, Kankakee. Society subscription, \$25.00.

**Individual Contributors.**

T. R. Foster, Kankakee.  
J. M. Gulick, Kankakee.  
L. E. Jacobson, Kankakee.  
C. T. Shrouts, Hospital.  
C. T. Smith, Kankakee.  
Chas. True, Kankakee.  
B. F. Uran, Kankakee.  
Iroquois—Unorganized.

**Individual Contributor.**

H. N. Henderson, Milford.  
S. R. Walker, Chebanse.

**22D DISTRICT.**

**Counties—**Vermilion and Edgar.

**Senator—**M. B. Bailey, Danville, Republican.

**Representatives—**Coulson V. McClenathan, Danville, Democrat; Geo. H. Gordon, Paris, Republican; Chas. A. Allen, Hoopesston, Republican.

**County Societies.**

**Edgar—**President, A. K. Mosely, Grandview; Secretary, H. McKennan, Paris.

**Vermilion—**President, H. F. Becker, Danville; Secretary, E. E. Clark, Danville. Society subscription, \$25.00.

**Individual Contributors.**

H. S. Babcock, Danville.  
P. H. Barton, Danville.  
H. F. Becker, Danville.  
J. B. Hazel, Hoopesston.  
Jesse H. McIntosh, Fithian.  
H. D. Rothgeb, East Lynn.  
L. B. Russell, Hoopesston.



24TH DISTRICT.

Counties—Champaign, Piatt and Moultrie.

Senator—Henry M. Dunlap, Savoy, Republican.  
Representatives—Evan Stevenson, Monticello,  
Democrat; Jno. H. Uppendahl, Dalton City, Repub-  
lican; Julius N. Rodman, Delan, Republican.

County Societies.

Champaign—President, A. S. Wall, Champaign;  
Secretary, H. E. Cushing, Champaign.

Individual Contributors.

J. V. Champion, Mansfield.  
H. E. Cushing, Champaign.  
C. P. Hoffman, Sadorus.  
J. A. Hoffman, Pesotum.  
H. C. Howard, Champaign.  
C. B. Johnson, Champaign.  
J. S. Mason, Rantoul.  
W. F. Matson, Monticello.  
Ellen Miner, Champaign.  
W. K. Newcomb, Champaign.  
Piatt—Unorganized.

Individual Contributor.

J. H. Abram, Atwood.  
J. V. Champion, Mansfield.  
F. J. Dudley, Cerro Gordo.  
L. W. Reid, DeLand.  
H. N. Vance, Bement.  
Moultrie—Unorganized.

Individual Contributors.

W. P. Davidson, Sullivan.  
C. W. Kinnery, Allenville.  
G. E. Loesch, Lake City.  
B. F. McMennamy, Bethany.

26TH DISTRICT.

Counties—McLean and Ford.

Senator—George W. Stubblefield, Bloomington,  
Republican.

Representatives—Jno. F. Hefferman, 106 E.  
Front street, Bloomington, Democrat; John A. Mon-  
tellus, Piper City, Republican; Wesley M. Owen,  
LeRoy, Republican.

County Societies.

McLean—President, J. Whitfield Smith, Bloom-  
ington; Secretary, E. S. Reedy, Bloomington.

Individual Contributors.

S. Bane, Ellsworth.  
H. F. Ballard, Chenoa.  
C. E. Chapin, Bloomington.  
D. T. Douglas, Colfax.  
W. E. Guthrie, Bloomington.  
O. E. Haering, Bloomington.  
P. G. Holderness, Chenoa.  
M. D. Hull, Bloomington.  
E. Mammen, Bloomington.  
N. K. McCormick, Normal.  
C. C. Sater, Atlanta.  
F. C. Vandervort, Bloomington.  
F. L. Wakefield, Heyworth.  
Ford—Unorganized.

28TH DISTRICT.

Counties—DeWitt, Macon and Logan.

Senator—Lawrence H. Stringer, Lincoln, Demo-  
crat.

Representatives—James M. Gray, Decatur, Dem-  
ocrat; Arthur J. Gallagher, Decatur, Republican;  
Carl Swigart, Weldon, Republican.

County Societies.

Decatur Medical Society—President, S. J. Bum-  
stead, Decatur; Secretary, L. M. Barnes, Decatur.  
Society subscription, —.

Individual Contributors.

Wm. Barnes, Decatur.  
Wm. H. Bell, Decatur.  
Wm. R. Boggs, Macon.  
E. J. Brown, Decatur.  
Cass Chenoweth, Decatur.  
W. J. Chenoweth, Decatur.  
F. J. Dudley, Cerro Gordo.  
H. C. Jones, Decatur.  
G. E. Loesch, Lake City.  
W. A. Melton, Warrensburg.  
E. A. Morgan, Decatur.  
M. P. Parrish, Decatur.  
S. L. Thorpe, Kenney.  
E. J. Brown, Decatur.  
R. Boggs, Macon.  
E. A. Morgan, Decatur.

DeWitt—President, A. E. Campbell, Clinton;  
Secretary, J. H. Tyler, Clinton.

Individual Contributors.

W. E. Chalstran, Lane.  
W. E. Davis, Farmer City.  
C. S. McLean, Hallsville.  
Jno. Wright, Clinton.  
Logan—Unorganized.

Individual Contributor.

C. C. Sater, Atlanta.

30TH DISTRICT.

Counties—Tazewell, Mason, Menard, Schuyler,  
Brown and Cass.

Senator—U. G. Albertsen, Pekin, Republican.  
Representatives—Henry H. Elliott, Kilbourne,  
Democrat; Jno. A. Petrie, Greenview, Democrat;  
Homer J. Tice, Greenview, Republican.

County Societies.

Schuyler—President, E. B. DeGraff, Rushville;  
Secretary, W. T. Harvey, Rushville.

Individual Contributors.

A. W. Ball, Rushville.  
J. A. Botts, Littleton.  
J. A. Harvey, Rushville.  
W. T. Harvey, Rushville.  
Tazewell—President, W. H. Conibear, Morton;  
Secretary, C. C. Muehlman, Pekin.

Individual Contributors.

Wm. Niergarth, Pekin.  
E. H. Weimer, Pekin.  
Cass—President, A. J. Glenn, Ashland; Secre-  
tary, J. A. McGee, Virginia.

Individual Contributor.

H. B. Boone, Chandlerlerville.  
P. N. Bowman, Virginia.  
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Counties—Rock Island, Mercer and Henderson.

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Counties—Douglas, Coles and Clark.

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## County—LaSalle.

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Counties—Christian, Shelby, Cumberland and Fayette.

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## Counties—Knox and Fulton.

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**Representatives**—D. J. Underwood, McLeansboro, Democrat; J. H. Miller, McLeansboro, Republican; A. W. Walker, Golconda, Republican.

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# The Illinois Medical Journal.

The Official Organ of The Illinois State Medical Society.

New Series, Vol. IV. }  
No. 11. }

Springfield, Ill., April, 1903.

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## HEMORRHOIDS: THEIR PATHOLOGY: INDICATIONS FOR AND TECHNIQUE OF OPERATIVE TREATMENT.\*

BY J. J. RAYSON PENNINGTON, M. D. CHICAGO.  
Professor of Rectal Diseases, Chicago Polyclinic.

Hemorrhoids are usually described as bluish-red knotty vascular tumors originating in a diseased condition of the blood vessels of the anal region. They are divided into three principal varieties, namely, internal, external and interno-external. The two former varieties may be subdivided still further. The muco-cutaneous junction is the dividing line between the internal and external varieties. The residence of the external pile is relatively permanent, always located on the distal side of Hilton's white line, while we might say of the internal variety that it is slightly migratory, that is, notwithstanding its origin is on the proximal side of Hilton's white line, or, better, perhaps, in the zone of the internal sphincter, that muscle, by reason of its tonic contraction, may, when the pile is large, either force it upwards above the levator ani zone and into the ampulla or pouch of the rectum (Fig. 1), or prolapse it downwards and out through the external sphincter (Fig. 2).

It is when they occupy the former location, doubtless, that we have the history of internal bleeding and the evacuation of stools of blood.

The principle factors entering into the etiology and pathology of hemorrhoids may be classed under the following heads, viz.; constitutional, mechanical and local. Under the former may be included those conditions where there is a weakened or debilitated circulation caused by impaired nervous energy which, doubtless, in many instances, is due, to the habits, customs, likes and dislikes of the individual.

Under the second head may be classed almost anything which interferes with the return-flow of blood through the rectal veins, as the gravid uterus, abdominal tumors, and especially those cases of obstipation where there is an accumulation of large fecal masses in the rectum. Cirrhosis of the liver, valvular disease of the heart, pulmonary emphysema, and obstructed portal circulation are also causative factors. Some writers, however, have observed that hemorrhoids are by no means a frequent complication of cirrhosis of the liver and cardiac disease. While they admit that these conditions increase venous pressure, yet they say that we must not lose sight of the fact that this pressure is not localized in the hemorrhoidal vessels, but is exerted uniformly over a large circulatory area. While gravity has always been recognized by authorities upon rectal diseases as one of the causative factors of hemorrhoids, Von Recklinghausen has gone a step farther and claims that it is the principal factor in their pathogenesis. While our observations may not corroborate his, yet we recognize it as a most potent aid in their development, as it matters not whether the individual is standing, sitting or lying, unless upon his side, the blood in the rectal veins must flow upwards and against this force.

Under the latter head should be included diseased conditions of the various tunics and blood vessels of the rectum.

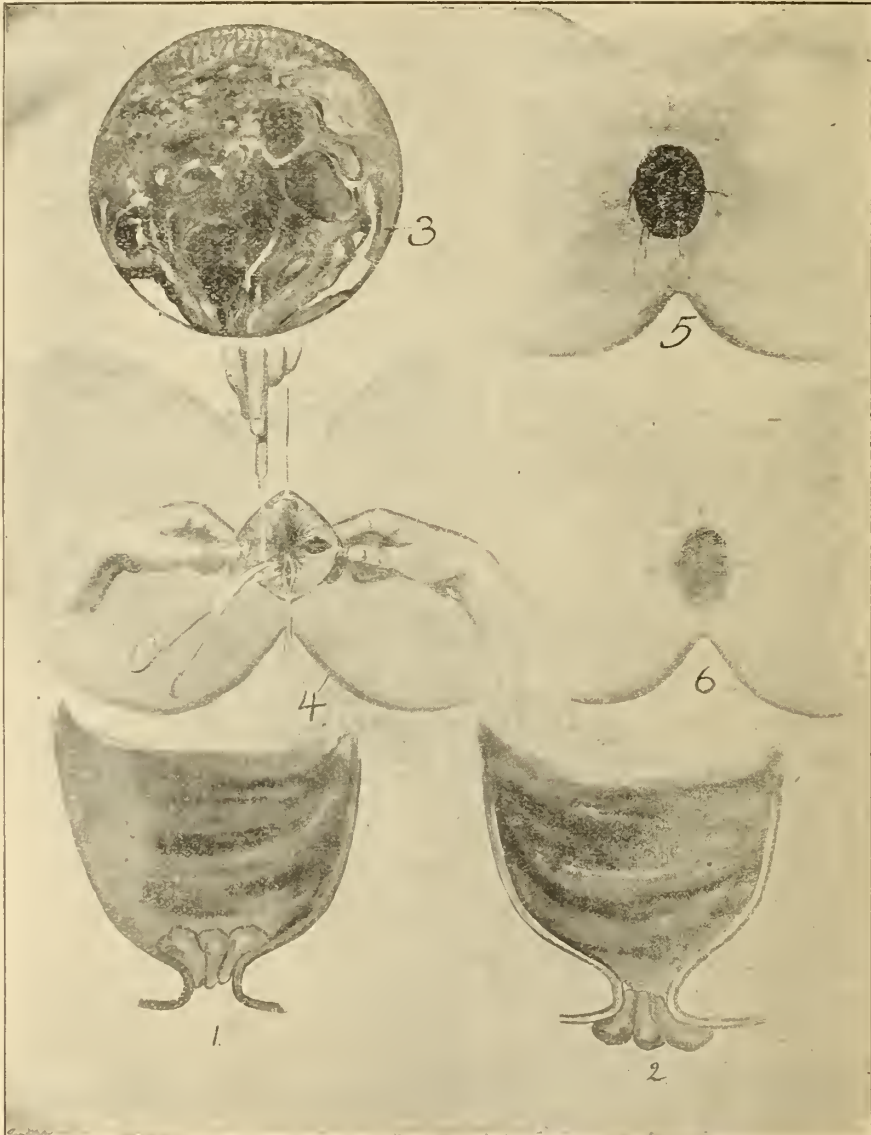
According to the investigations of Reinbach, hemorrhoids are true angiomas, whose development, which may begin in early childhood, depends on a new formation and cavernous metamorphosis of the blood vessels, and may be quite independent of any obstruction to the blood flow.

The report on specimens of internal hemorrhoids submitted to Dr. W. A. Evans, of the Columbus Medical Laboratory, for histologic and pathologic examination showed that the principal pathologic points of a hemorrhoid occur in the submucosa, and that the tumors

\* Read at the 52d Annual Meeting, Quincy, May 21, 1902.

consist of dilated blood vessels and blood lakes, covered with injured mucosa and sub-mucosa. (Fig. 3). Some of the vessels showed a marked endarteritis obliterans, and between the venous lakes there seemed to

can with greatest safety, ease and simplicity radically remove the pathologic structure, the diseased blood vessels and blood lakes and, at the same time, preserve the contour of the anus and facilitate the reconstruction of



be no specific wall except that of the endothelial lining.

This report corroborates, in a great measure, the observations of Reinbaeh. Hence, it seems to me that we should adopt some method of operative procedure whereby we

the crippled or deformed mucosa and sub-mucosa.

That method is surely not to be found in the ligature, clamp and cauter, Whitehead's, and many other conventional methods I might mention. In fact, seems to me that

anyone, at all familiar with the laws of physics, who will recall the anatomic structure of the rectum, its contour and the relation of the blood vessels to the mucous membrane, will readily recognize the advantages of an extraanal over an intraanal method of operating. In the application of the latter method, as ordinarily employed, it is very dif-

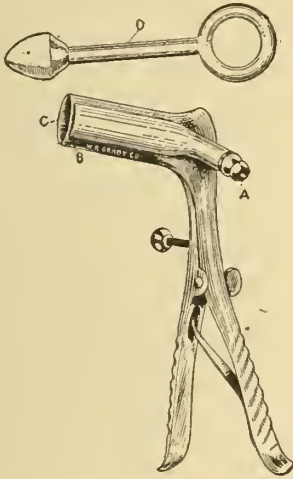


FIGURE 7.

icult, if not impossible, for one to do a radical operation on a well-defined case of internal hemorrhoids, and not remove an excess of mucosa and submucosa, with stricture as a possible sequel. Gerster recognized this when he, eight years ago, warned against the removal of more than the uppermost third of the hemorrhoidal nodule in the clamp and cautery operation. In fact, it cannot be denied that in the employment of such methods one removes much healthy tissues that should be preserved and fails to remove diseased tissue that should be excised.

Hence, it occurred to me that the most rational way of treating this condition would be by everting the pile-bearing area, exerting *vis a tergo* pressure upon the base of each hemorrhoid, then removing an ellipse from the apex of the tumor commensurate with its size, and dissecting out the angioma, when the remaining walls of the tumor would collapse and practically cover the denuded surface after the bowel was returned to its nor-

mal state. This gave rise to the origin of the method presently to be described.

*Indications for Operative Interference.* It is very difficult to state specifically just what cases should and should not be operated upon. The mere presence of hemorrhoidal tumors is not sufficient reason for operation, yet their existence can do no good and may do much harm. Speaking in a general way, however, I would suggest the following indications for operation.

1. Frequent recurring hemorrhages, even though small in amount. This continual loss of blood must, sooner or later, be followed with profound anemia, accompanied with pallid features, dizziness and palpitation of the heart.

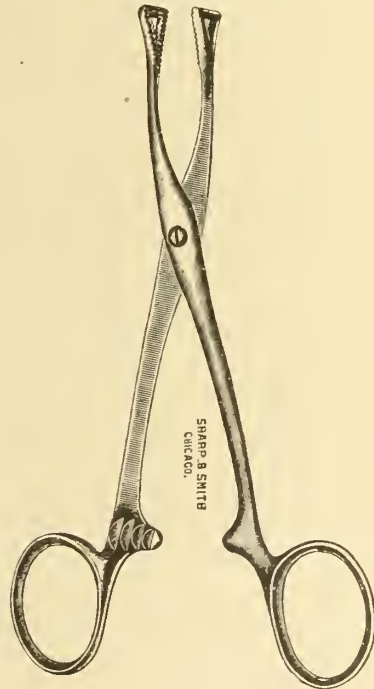


FIGURE 8.

2. Frequent protrusion of the tumors, causing pain and distress to the individual.
3. Repeated attacks of inflammation.
4. Those cases in which the piles remain outside the anus after defecation and require manual replacement.
5. Those which protrude on slight exertion, and also have to be replaced.



There yet remains another class of cases in which it may be more difficult to decide when and when not to operate, those associated with visceral diseases. Among the more important of these are those cases of symptomatic hemorrhoids due to hepatic or cardiac disease. In hepatic cirrhosis, if the hemorrhage is not very great, though occurring quite frequently, and the patient is fairly well nourished, it might be well not to operate. Should the hemorrhage be excessive, however, and the patient run down, operate, but do not fail to instruct him that such wounds may be slow in healing and that he is likely to have a recurrence.

In cardiac insufficiency, if there is much loss of blood, operate. The daily loss of blood further increases the labor of the already weakened heart.

Patients above seventy years of age, if in good health, may be successfully operated upon, but the hemorrhoids should be more symptomatic at this age than in one in the prime of life to indicate an operation. The same caution might be suggested with reference to other complications, such as locomotor ataxia, paraplegia, hemiplegia, pregnancy, etc.

*Preparation of the patient.* In preparing the patient, I prefer to administer a good cathartic, usually two to four grains of calomel in broken doses, twenty-four to thirty-six hours before the operation, and in about ten or twelve hours after the calomel has been taken to give one-half ounce of rochelle or epsom salts. Then six or eight hours before operating give a good colonic flushing, repeating these flushings until the water returns clear and two hours before operating give an enema of about one half pint of cool water which should be immediately passed. This method of preparation gives a clean field in which to operate. Should more water than this be administered, a part of it is apt to be retained in the sigmoid and chambers of the rectum, and is likely to soil the field sometime during the operation. If you follow the advice contained in most of your text books—giving a cathartic the previous evening and a high rectal injection about an hour before operating—you will fre-

quently be confronted with a dirty field in which to labor. The patient, is then anesthetized and held upon the operating table in the lithotomy position. I always operate with the patient in this posture and I sit on a rather low stool. I formerly placed my patient on one or the other side, but it cannot be gainsaid that the lithotomy position offers the best view of the field. The patient is then shaved if this function has not been previously attended to. One word about shaving the patient. Nothing embarrasses and enrages me more than to have a lady patient brought to the operating table with not only the anus, but the entire pubes shaven. It is a practice indulged by many of our hospitals and it should be condemned. It is an unpardonable insult to any woman to shave her pubes for a hemorrhoidal operation. It is proper to shave around the anus, but not the mons veneris. This done, the anal region is then scrubbed with soap and water and rinsed with alcohol followed by bichloride solution. The sphincter is then slightly, gently and carefully dilated with the fingers and the rectum irrigated through a bi-valve speculum with an antiseptic solution, usually 1-3000 bichloride followed with normal salt solution. (Fig 7.) Each anal quadrant is now grasped at the muco-cutaneous junction with a pair of T-forceps; these are held by an assistant. They are constructed so as to secure the strongest grasp possible with least injury to the tissues. (Fig. 8.) This is very important, especially when operating under infiltration anesthesia. By means of these instruments, the anus is everted and the internal tumors exposed. In fact, by this method of eversion of the anus, you see each hemorrhoid just as distinctly as the fingers on one's hand. There is no other method of exposing this field that will give you such a full and complete view.

Now seizing with the full hand the forceps attached to the posterior quadrant, fully evert it and make pressure against the base of the hemorrhoid with the knuckle of the index finger, which places the mucous membrane covering it on a tension. Then, with a pair of scissors, sharply curved on the flat, remove an ellipse from the apex of the over-

stretched covering of the hemorrhoid commensurate with the size of the tumor. This opens the blood lakes and permits most of the blood in the tumor to escape. All of the angiomatous tissue is now carefully removed, when the remaining wall of the hemorrhoid collapses. This leaves a very small area of denuded surface. Each quadrant in regular order is treated in like manner. A stream of hot sterilized salt solution (115° to 125° F.) flows over the field continuously during the operation. (Fig. 4.) Spurting vessels, if any, are caught with a pair of forceps and thoroughly twisted. Should this fail to control the hemorrhage, throw a ligature around the vessel and ligate it. The same precautions should be exercised in regard to hemorrhage in this as in any other surgical procedure.

The T-forceps are then removed and all external tumors and tabs of skin cut off, care being taken not to make an incision in the muco-cutaneous junction, when it can be avoided, as this is the most sensitive point around the anus. This same precaution should also be observed when removing the internal tumors. The field is then dusted with some antiseptic powder, and dressed in an extended posture by means of a rubber-covered tampon introduced through a bi-valve speculum.

The tampon is allowed to protrude about 1.5 inches beyond the anal orifice. Gauze is carefully wrapped around the protruding portion and packed close to the anus. The anchoring string of the tampon is wrapped around a piece of gauze held close to one side of the tube, and woven in with the other dressings, so as to prevent the tampon's slipping into or out of the rectum. Over this is placed gauze, cotton and a T-bandage, which is made quite taut. The patient is then placed in bed, and usually given a hypodermic of morphia, if not contraindicated. It can not be denied that operations in this region are more or less painful and I give my patients opiates or other anodynes to control pain.

By operating in this manner, there are no tender and obstructive stumps to slough, nor nerves caught and squeezed, producing most excruciating pain, as there are when the ligature method is used (Fig. 5); neither are

the nerves and tissues painfully burned, as when the clamp and cautery are employed. In lieu of this there is a free and unobstructed outlet through the anus, and a fibrinous exudate is deposited over the operating field, which exudate is neither destroyed nor disturbed upon removal of the dressings. (Fig. 6.) Moreover, the danger of stricture is obviated, as the normal caliber of the bowel is left practically covered with mucosa and submucosa. Neither is the anal orifice contracted, as it necessarily is after either of the above operations.

At the end of forty-eight hours the patient is given a cathartic and the tampon removed. Removing it is easy and painless. The movement of the bowels is usually painless, and there is, as a rule, little or no bleeding.

From this time on, until convalescence is well established, the parts should be washed or irrigated daily with an antiseptic solution, and dusted with some antiseptic powder, or sterilized vaseline applied. After the bowels have moved, the patient is instructed to keep them soft for two or three weeks. Should the patient complain of pain or an aching sensation, a hot Sitz bath of twenty minutes' duration is given. As a detergent, small pieces of wet cotton or cottonoid are used. Never under any circumstances allow the patient to use paper or other hard and rough substances as a detergent until the parts are thoroughly healed.

This method of operating, which I have now employed in more than two hundred cases, in many of which local anesthesia was used, has been, by far, more satisfactory than any method previously used. My observations teach me that it is the most rational and radical method we have for operating on this very prevalent malady. No other method will give your patient so little pain, no other will get the patient out of bed in so short a time, and no method is more radical. I insist, however, that the technic must be carefully observed to the letter. It is very quickly and easily performed, and as a rule the patient is out of bed in a week, and often in less time. In fact, it is not uncommon for him to resume his work on the fifth or sixth day after the operation.

## ACUTE GASTRO-ENTERIC INFECTION OF INFANTS.\*

BY MARGARET TAYLOR SHUTT, M. D.

Pathologist of St. John's Hospital, Springfield.

Every year our large cities are invaded by an epidemic of a very serious and deadly character. Hundreds of young lives are annually destroyed by a preventable disease caused largely by filth, and yet the general public views this yearly slaughter of the innocents with equanimity only because it has always occurred, and it is not generally recognized that it could be prevented.

Since the diarrhoeal diseases occur most frequently in the hot months it is understood that heat is the main factor, but the laity does not appreciate that this is true only in an indirect way. Indeed it has only been a few years since the profession taught that gastro-enteritis was a form of heat stroke.

The ordinary mother still attributes her child's diarrhoea to the fact that it is teething or that it is in its "second summer," and fails to realize that her baby is suffering only because it has been fed upon a contaminated milk food, or that in some other way an infection due to dirt has been introduced into its alimentary canal.

Heat is a cause of gastro-enteric infection in several indirect ways, by its effects upon food, upon the child and upon its environment.

In the first place the child most prone to be infected is the one who is artificially fed, and heat is favorable to the growth of germs in any suitable culture medium. The food of the child furnishes an ideal culture fluid.

Secondly, heat causes dust by drying the soil and the filth in our city streets, and in this dust the bacteria that cause putrefactive and fermentative changes are carried in all directions, so that not only milk exposed for sale, and the food prepared for the child are contaminated with it, but also the carpet on which the child creeps, the toys it is so prone to put into its mouth, and its own dusty hands become dangerous sources of infection.

Thirdly, the intense heat has a depressing

effect on the child's vitality, and it becomes a more ready prey to any disease, hence it is not able to resist the effects of toxins generated in its own alimentary canal.

Very frequently little children suffer from unduly heavy clothing, in addition to the atmospheric heat.

Lastly the child suffers from unusual thirst in hot weather, and becomes fretful. The average mother's only solace for a crying child is food, so its stomach is over-loaded.

Many children suffer from improper feeding, irrespective of the effects of hot weather on food.

Last summer, while working in a New York dispensary, I treated seventy-five or eighty cases of fermental diarrhoea in infants. A large proportion of these cases were fed on a certain popular brand of condensed milk. These children, though fat and apparently well nourished, at the beginning of the infection, became emaciated very quickly and showed little resisting power. Their stools were intensely acid, and excoriated the buttocks.

In the cases where cow's milk was used, it was usually a low grade of milk, bought from the open can at the corner grocery store. This was bought not alone that such milk is cheaper, but also because in the tenement house districts where the epidemics of diarrhoeal diseases are most frequent, often the shops have no other kind of milk for sale. Hence such benevolent institutions as the Trinity Diet Kitchen of Chicago and the Nathan Strauss Milk Charities of New York, where mothers for a nominal fee (or for nothing, if they are very poor,) may procure clean milk for their babies, accomplish an amount of good that is usually not appreciated by those who do not know the slum districts of our large cities.

Mothers do not always realize the necessity for a milk that has been kept free from germs from the time it is drawn from the cow. They know that by pasteurizing or sterilizing it they can kill any germs it may contain, but they do not know that the toxins these germs produce are not destroyed by exposure to intense heat, and that milk that has been boiled for

\* Read at the 52d Annual Meeting, Quincy, May 21, 1902.



a long time may contain deadly poisons which do not in any way affect its odor or flavor.

Other mothers do not realize that milk that has once been sterilized or pasteurized needs any especial care afterwards, that it must be subjected to the action of steam in the bottles from which it is fed, and afterwards kept on ice carefully sealed. They have not been taught that milk so treated has lost some vital quality, and that it is more readily infected than if it had never been so treated.

Only lately I talked with a mother who told me that she pasteurized her child's food. I found that what she called "pasteurizing" it, was bringing it to a temperature of 157° in an open vessel. After which it was emptied into a second vessel in which it was kept in an ice box, from which at intervals a small quantity was removed and diluted and put into a nursing bottle for each feeding. This mother believed that her child was absolutely safe from any infection on account of that cabalistic work "pasteurize."

While the breast fed child is less often a victim of severe diarrhoeal trouble, in the tenement house districts, few children are exclusively breast fed after the first few weeks. Usually they are carried to the table and as soon as they are old enough to show any desire for food their over-indulgent mothers give it to them, even if it happens to be strong coffee, stale beer or boiled cabbage, as in instances I have known. When they are a little older they browse about the streets for themselves, and often find such pabulum as apple skins and over ripe bananas.

When strictly breast fed children suffer, it is usually due to over-feeding, to infected dust on fingers and toys, or to unclean nipples.

It has been proved through bacteriological studies by Baginski, Booker and others that the infection is not due to any specific germ, but that there are many germs, whose chief action is to cause fermentative and putrefactive changes, that may cause the disease, by generating toxins in the alimentary canal.

The early symptoms are usually vomit-

ting and nausea. Very soon there is fever and pain, and the stools become frequent and abnormal. Prostration soon results.

The fever usually ranges between 100° and 103°, though in very serious cases the temperature may go much higher.

The stools are from five to twenty a day in number, and are usually small, and of an offensive odor. Sometimes they are greyish and pasty, containing shreds of undigested curds. More frequently they are some shade of green and they are this color when first passed. Very frequently normal infantile stools become green after having been passed as a result of the oxidizing effect of the air.

In cases of true cholera infantum, which are more infrequent every year, the stools are very large and watery.

If the disease has lasted several days the discharges may contain pus, mucus and blood. When this occurs it shows that inflammatory and possibly destructive changes have occurred in the mucus membrane, and that we have more than a simple toxæmia to deal with.

In some instances the prostration is extreme even after a very few hours. This is always so in true cholera infantum, but also in cases where the stools are small and infrequent there may be hyper-pyrexia convulsions, heart failure and death in a few hours. This is especially likely to happen when opium has been administered, and nature's efforts to rid itself of poisons by diarrhoea have been frustrated.

When the symptoms noted occur in hot weather there is rarely any difficulty in diagnosis. Occasionally the onset of a pneumonia or one of the eruptive fevers may be similar.

The outlook depends upon the child's vitality, upon the time before treatment begins, and upon the intelligence and tractability of its care-taker. The prognosis is grave in children previously debilitated by other disease, and is almost hopeless in cases of the choleriform type.

Since Summer diarrhoea is a disease that can be prevented by intelligent care, it is the duty of the physician to educate mothers. The means of prevention are chiefly

to keep the child clean and cool, and to give it a proper quantity of clean and wholesome food.

Children should be kept in the open air as much as possible, and should sleep in well ventilated rooms.

Daily bathing of the child should be insisted upon, and in very hot weather frequent sponging of the child with cool water will increase its comfort and add to its safety.

The child's toys and its surroundings should be kept free from dust, so as to exclude this chance of infection, and mothers should be taught the necessity for scrupulous cleanliness of their nipples when they nurse their children, and of their hands when they prepare an artificial food.

Since mother's milk is the only perfect food for infants, the physician ought to use every effort in his power to secure it to the child. Often the quantity may easily be increased by attention to diet, and the quality may be improved by dieting, exercise and tonics. Even when the supply is scanty and cannot be increased, if there is enough to furnish two or three feedings for the child daily and if it is of good quality, it should be continued; enough bottles being given in addition to furnish sufficient food.

In cases where weaning is absolutely necessary, a healthy wet-nurse should be secured if possible, though this is a luxury for the very few.

When it becomes necessary to resort to artificial feeding it is the doctor's duty to give explicit directions in regard to the preparation of the food, using fresh cow's milk properly diluted and modified. If he has access to a milk laboratory his work will be only the prescription of definite proportions; if not, he must see that the food is just as carefully prepared. The chief necessity is cow's milk of a good quality from healthy cows kept clean and cool from the time it is drawn from the cow, until it is modified. Such milk may now be obtained in all our large cities. Milk of this quality requires no pasteurization or sterilization, and properly modified forms the only safe substitute for mother's milk.

In very hot weather the child should be

given less food than usual, the deficiency to be made up by water that has been boiled and cooled.

When an attack has developed the chief indications are to stop the source of irritation, that is, any milk food, at once; (This must be done whether the child is on the breast or artificially fed,) to remove all the offending material from the alimentary canal as quickly as possible; to allay vomiting; reduce fever; furnish a food that will not encourage bacterial growth; if possible, to destroy germs present. and to stimulate if there is much depression.

Washing out the stomach will usually stop the vomiting, and if not, calomel in 1/10 gr. doses repeated hourly will usually quiet the stomach besides clearing out the intestines.

Whenever the stools are small and offensive the colon should be flushed out. Often a single time is all that is necessary, and twice a day is always often enough. Usually the child struggles very little during the irrigation.

A well oiled soft rubber catheter about the calibre of a lead pencil is used, with either normal salt or a weak boric acid solution, the temperature depending upon that of the child. Enough of the solution must be used to insure its returning clear. As soon as the tip of the catheter passes the anus the water is turned on, so that the current may distend the bowel ahead, and so facilitate its introduction higher. The return flow may be prevented by pressing the buttocks together until about a pint of fluid has been introduced so that the colon is thoroughly filled, then the solution must be allowed to escape, either at the side of the catheter, or by removing and re-inserting it. By these means much undigested food, and foul smelling faecal matter is washed out, and the temperature is safely and speedily lowered.

If there is no nausea, castor oil should be given at once, to clear out the rest of the canal. If there is nausea, the calomel alone in 1/10 grain doses, repeated hourly until the characteristic odorless calomel stool appears, must be depended upon.

The child must not return to a milk diet

until the stools become normal. For the first twelve hours or more the child will do better without any food, giving it only cold water that has been boiled. Later a suitable substitute must be furnished. Animal broths, egg water and barley water, either plain or dextrinized have all been used, but I prefer temporarily one of the liquid preparations of beef peptonoids now put up by so many drug houses. I have been in the habit of giving one half or one teaspoonful of the peptonoids in two or three ounces of boiled and cooled water every two hours until the stools become normal. This affords a certain limited amount of nourishment in a very easily assimilated form, and also a little alcoholic stimulation. Children always take it readily. In addition the child is always to be given all the cool boiled water it will drink.

When the fever continues high, the mother is instructed to sponge the child frequently with cool water.

If there is great depression, heart tonics must be given as indicated. Stryehine is usually most effectual.

After the bowels are thoroughly cleared out, I usually give bismuth subnitrate in five or ten grain doses every two hours until the stools become black or dark green.

Usually this treatment is sufficient to relieve an attack, but occasionally after the stools become normal in quality and other symptoms disappear, the diarrhoea continues, due only to an increased peristalsis. In such cases, and in such cases only, I give opium with great caution, either in the form of 1-4 grain of Dover's powder or a few drops of paregoric.

In cases of true cholera infantum treatment is much less satisfactory. The flushing of the colon is unnecessary, excepting for stimulating effect, and this can be more quickly and effectually secured by introducing warm saline solution under the skin.

During the course of the treatment much can be accomplished by removing the child to a cooler atmosphere. This is especially effectual where the child lives near a large body of water, and may be quickly and readily removed. In such a case a fear-

fully depressed and apparently moribund child in a few hours may revive like a wilted flower.

The after care of these children is very important. In some instances tonics are necessary, but the chief necessity is an outline of diet. Breast fed children may usually be safely and speedily returned to the breast, though at first they should be allowed very small quantities of milk at long intervals gradually increasing the quantity and shortening the interval.

In cases artificially fed it is often exceedingly difficult to return the child to a milk diet. It may be gradually added in small quantities to rice or barley water. Sometimes the artificial foods are of temporary use.

In difficult cases it may be necessary to keep the child on cereal foods and animal broths for weeks. In other cases a weak modified milk partly peptonized may be given before even small quantities of undigested milk can be retained.

In every instance where a child is returned to a milk diet it must be done with great caution. Very small quantities given at first, and gradually added to until a food of the usual strength and amount is given.

In serious cases children are often intensely depressed and debilitated, and for a long time need careful watching.

#### Discussion.

**Frank X. Walls, of Chicago:** The essayist has gone into this subject from etiology to treatment in a manner with which I am most heartily in accord. While listening to the paper, it occurred to me that in connection with the diagnosis of gastro-enteritis a word might be said as to the frequency with which a diagnosis of gastro-enteritis is overlooked, and a diagnosis of meningitis substituted for the real disorder. We find that to be the case very frequently among the poorer class of people, where the diagnosis of meningitis is a common one. It is common to hear in our dispensaries that several members of a family died of meningitis. In many cases of gastro-enteritis the symptom grouping is of the meningeal type. The children will have one or more convulsions, they will become stiff and rigid and possibly go into a condition of unconsciousness. This grouping of symptoms so nearly resembles that seen in meningitis that that diagnosis is very frequently made.

The symptom-complex of meningismus or pseudo-meningitis being so common in children, we should always consider in every case which appears to be meningitis whether it may not be one of meningismus. Again, it seems to



me that a word might be said for another group of cases of gastro-enteritis, a group which might be called secondary cases of gastro-enteritis. Of course, the paper considered only so-called cases of primary gastro-enteritis. Children often have a gastro-enteric complication in the course of many infectious diseases. In order that we may appreciate these secondary types of gastro-enteritis, it may be well to classify them in certain broad groups. One group should be called the eliminative cases of gastro-enteritis, cases in which there is an elimination through the bowel of certain toxic products. A very severe gastro-enteritis may develop from the elimination of such toxic products by the alimentary tract, and in children especially this form must be recognized.

Another type might be considered as auto-genetic cases. The balance between digestion and indigestion in children is so carefully poised that any slight cause is likely to convert the normal digestion into indigestion. Normal digestion occurs in children, possibly because the process of digestion is carried on so quickly and perfectly in the alimentary tract, and anything which would divert these processes would have a tendency to produce a gastro-enteritis. Almost all the diseases of childhood may, by interfering with gastric or intestinal digestion, have a tendency to bring about an autogenetic gastro-enteritis. This must put us on our guard.

Another classification may be considered as those cases of gastro-enteritis which occur in the course of an acute infectious disease, cases which are nearly always accompanied by symptoms referable to the gastro-intestinal tract. This complication must frequently be differentiated from primary cases of gastro-enteritis. Measles is very often ushered in with diarrhoea or vomiting; scarlet fever likewise; diphtheria may frequently begin as a gastro-enteritis. These secondary infections are met with early and late in the course of these infectious diseases. In many cases the lesions in the bowel are extensive, although in some there is simply an erythema. Bacteria and their products may produce local lesions in the bowel, emboli or even ulcerations.

**L. H. Mettler**, of Chicago: I want to emphasize the statement made by Dr. Walls that great care should be taken in differentiating a meningitis, or, rather, a pseudo-meningitis from these conditions of gastro-enteritis. Many of the symptoms, especially the minor ones, simulate a meningitis very closely, but it seems to me that a strict examination of the case ought, in the vast majority of instances, to determine whether you have an inflammation of the meninges, or whether it is a secondary infection of a mild character, acting upon the cerebral centers. True, you will have the convulsions, the modifications in the skin, the vomiting, and other symptoms which seem to point to a nervous irritation or inflammation of the central nervous system, but we are not prepared as yet to say that these are of the nature of true meningitis. Of course, we do not have the eye symptoms. We can usually determine whether the child is suffering from an intense headache; at other times we can

suspect it. It seems to me that the term pseudo-meningitis is well applied in these cases, or, perhaps, it would be still better not to use the term meningitis at all, as they are, in all probability, true peripheral disturbances of the central nervous system, or, what I am more inclined to believe, simply direct poisoning, a mild form of toxemia, of the central nervous neurons. This intoxication gives rise to those various manifestations pointing toward the central nervous system, or a suspicion, as Dr. Walls very nicely pointed out, of meningitis. It seems to me, however, that a meningitis, with its definite symptom-complex, can be very well distinguished, even in children, from those disturbances which are merely a delicate involvement of the central motor neuron, a very mild form of auto-intoxication.

**A. C. Cotton**, of Chicago: I agreed fully with all that I could hear of the paper, and I think everyone present does the same thing. In discussing the feeding of the child, the essayist made the remark that the best food was the mother's milk, that is, nursing the child from the breast. From that time on, I seemed to lose interest in everything else contained in the paper, as it really was the most important question submitted. It seems to me that, important as the subject of gastro-enteric infection is, there is a subject of much greater importance than the treatment of gastro-enteric infections, namely, their prevention. Last night I went with a doctor to see a child, twenty months old, a nursling, who was moribund when I arrived. The child had been eating peanuts Friday night, and then the mother wondered how it was that her baby was taken sick. That, of course, had nothing to do with the mother's milk.

Two or three days ago, while I was waiting on a corner for the street-car, I overheard a conversation between a grocery-man and a boy, who had applied for a job, and had evidently been employed. The boy was earnestly asking the man for instructions in regard to the delivery route; how he was to go over the route, and what he was to do under certain circumstances. Finally he asked the grocer what he should do in a certain emergency. I got interested, and drew a little nearer. Among other things he asked what he should do if the wagon got "spilled" over and the horse break the harness. Should he attend to the horse, or should he look after the goods in the wagon? The grocer turned round, looked at him, and said, "we don't expect you to tip the wagon over." I thought that was a good answer, and it is practically the same with us. As soon as the profession takes this stand in the feeding of infants, we will not expect nurslings or sucklings to have gastro-enteritis. Then you will put the blame just where it belongs. We need not blame the cow nor the nurse, and we will not have to talk so much about sterilizing milk. We bring matters down to first principles, the mother's milk. You say the mother does not give milk. Well, the mother ought to give milk, and until we know why mothers don't give milk, or why they stop giving milk, or why they wean their babies, I think the other questions are of minor importance. We

should take the bull by the horns, and meet it right here. The mother should nurse the baby, and we should not rest content with any other thing. It is the question of paramount importance, why don't the mother nurse the baby? No laboratory should be allowed to rest, no way should be left unexplored until we get nearer to an understanding of the physical chemical question of milk production in the mammary gland of the mother. As long as nothing at all can be done to promote the secretion of milk for the benefit of the nursing, I think it is a question of paramount importance to ascertain the reason why. Therefore, as soon as the author said that the breast milk is the best food for the baby, I seemed to lose all interest, because it brought all these things to my mind, and the other things in the paper were really of minor importance.

**J. C. Cook, of Chicago:** I cannot but heartily commend Dr. Shutt's paper. The essayist, as well as Dr. Walls and Dr. Cotton, has avoided one of the principal questions connected with gastro-enteritis. These acute cases that yield in a day and present symptoms of pseudo-meningitis are simple enough, and all it requires is to empty the alimentary canal of the offending substance, and give proper food, if it can be found. However, Dr. Cotton is theorizing when he tells us to make the mother give milk, for he knows, as well as I do, how many times that is impossible, and, furthermore, how many times the milk does not agree with the child. The part of the subject not particularly dwelt on are the chronic cases, the cases that have passed the acute stage, and that do not have meningitis. In three thousand cases treated at the Jackson Park Sanitarium, in Chicago, about twenty-five per cent. came in with evidences of meningitis, but not one of them developed a true meningitis. So that if we see meningitis at all in these cases, we must do as Dr. Walls did, and call it meningismus or pseudo-meningitis. It is the chronic cases that tax the physician's ingenuity, and bring him to his wits' end, the cases that have passed the acute stage, the cases in which we find ulceration of the bowel. Many times it is a serious question what to do to prolong the life of the infant for one more day, in the hope that the weather will change and thus hold out some chance of recovery. Last summer we tried an expedient at the Sanitarium that was attended with remarkably good results. We infused these infants with normal salt solution, the infusion being made in the back, and many of those cases that came in moribund and almost beyond relief were relieved temporarily. The salt solution seems to increase elimination by acting particularly on the kidneys. The trouble with these cases is that there is not enough done early in the disease to be of any particular value. I should like to see others try this salt solution method in the treatment of these cases, as I am convinced it is of some value.

As has already been said, the cause of the meningeal symptoms in cases of gastro-enteritis is undoubtedly the absorption of toxins through the alimentary canal or of some toxin taken with the food, or a toxin generated in the alimentary canal. The kidneys eliminate perhaps as many of these toxins as any of the emunctories. By infusing the child with fluid on which to subsist, fluid on which the heart may act, elimination may be increased, as was conclusively proven in our Sanitarium last summer, and we came to look upon it as one of our most valuable remedial measures. We always used the normal salt solution, but sometimes added enough salt to bring the specific gravity of the solution up to that of the urine in order that we might increase kidney action thereby.

The feeding of infants in this stage is much too broad a subject to go into in this discussion, and what has already been said covers the ground. I heartily agree with the essayist in endorsing the use of peptonoids in these conditions. We use a large quantity of them in the Jackson Park Sanitarium.

**M. S. Marcy, of Peoria:** The essayist well said that the mother's milk is the true ideal food for the infant, although there are some exceptions to that. The mother's milk is not fit for the baby after she has eaten boiled cabbage, nor after she has done a large washing for a family of eight or ten, and is very much over-heated. Neither is the mother's milk fit for the baby if the mother is a victim of tuberculosis. There are many other conditions in which the mother's milk is entirely unfit for the infant, and where it is responsible for many infantile diseases. I am a strong advocate of infant feeding by the mother, but I am convinced that there are many instances when anything else than the mother's milk would be much more desirable for the baby.

**Dr. Shutt (closing the discussion):** I heartily agree with Dr. Cotton that the mother ought to nurse the infant, and I believe doctors should use a little more persuasion and induce the mother to do so. There are many reasons why some mothers do not nurse their babies, and I am rather afraid that in order to bring about the desired state of affairs it would be necessary to entirely reconstruct our present social structure. Society is responsible for many undesirable conditions. Most of the cases of gastro-enteritis occurring in the higher class usually are found in families where the mother is a very prominent member of society. She lives on a very rich diet, keeps very irregular hours, dresses improperly, in short, does everything she ought not to do, and such a woman cannot be expected to give good milk or even any milk at all. Doctors can do much to remedy this state of affairs although I am certain that it cannot be done in a short period of time.



SIX YEARS IN A DERMATOLOGIC CLINIC.\*

A Report of service with remarks upon the treatment of more Common Skin Diseases.

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The subject of this paper is an analysis of the dermatological cases treated in the years 1896-1901 at the United Hebrew Charities Free Dispensary of Chicago. It is a story of the morbidity of the poor, and partly, also, a mirror of their life.

The Dispensary is located in the so-called Ghetto district of Chicago, where the chief unsanitary conditions are darkness, lack of air uncleanness and poisonous gases. Robert Hunter, in his publication "Tenement Conditions in Chicago," thus describes the state of affairs in this district:

"Musty, fetid rooms which cannot be ventilated because of brick walls overshadowing the windows, inevitably accumulate in their dark corners dirt, mold and vermin. \* \* \* Emanations from the body and foul air in dwelling and sleeping rooms have no outlet except by thorough ventilation. \* \* \* An average of three persons living in one room with 200.64 cub. ft. of air per person to breathe in. \* \* \* Wretchedly clad and poorly nourished, fortunate if they have a basket of slate coal, they crowd together to economize the warmth which their bodies give out. \* \* \* On hot nights it is common to see the people escape from their stifling houses and seek slumber and fresh air, stretched out over the festering contents of the sidewalk garbage box. \* \* \* It will be possible to realize how much there is in all of these conditions to degrade the individual. Surrounded by foul conditions the people almost lose their desire for cleanliness. It is almost impossible for an individual to keep free from the filth

of the streets and alleys, the yards, courts and passage-ways."

No wonder that the skin diseases of these unfortunate people are mostly of parasitic origin, the parasites belonging to every kingdom of God's wide world, human, animal, and vegetable.

It has seemed to me worth while to classify all the cases which I treated during the six years, arranging them into groups of five years up to the age of 20, and of 10 years each above that age.

There are some interesting and I believe significant generalizations to be made from the observations.

1. Almost all the cases reported belong to the classes of infectious inflammations or parasitic disease. Living, as these people are obliged to live in the narrowest quarters, where privacy is impossible and due care of the person not to be thought of, such diseases once contracted are most difficult to control and their spread under these conditions is inevitable.

2. In some of the parasitic dermatoses the etiological factor can be readily deduced from the data tabulated from the clinical record. Thus, for instance, in scabies, which reaches the appalling number of 203 cases or 8.5 per cent. of all skin cases The table of the distribution of the cases in the various months of the six years is as follows:

Month.	Cases.
January .....	17
February .....	10
March .....	15
April .....	8
May .....	13
June .....	4
July .....	11
August .....	45
September .....	36
October .....	22
November .....	7
December .....	15

The sudden jump towards the autumn months can be interpreted only by the swelling of the immigration tide in these months. Most of the patients declared to having contracted the disease after their arrival.—A

\* Read at the 52d Annual Meeting, Quincy, May 21 1902



TABLE OF PATIENTS TREATED AT THE DERMATOLOGICAL DEPARTMENT OF  
THE UNITED HEBREW CHARITIES FREE DISPENSARY  
FOR THE YEARS 1896-1901.

AGE.....	0-5		5-10		10-15		15-20		20-30		30-40		40-50		50-60		Over 60		Total Males.	Total Females.	Grand Total.
SEX.....	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.			
Acne and comedo.....					2	8	30	42	9	13	1	6							42	69	111
Alopecia.....							2	3	3	2									5	5	10
areata.....			2	1	1	1			2	1									5	3	8
Bromidrosis.....							1		1		1								1	2	3
Callositas.....									1	2	1								2	2	4
Chloasma.....									2											2	2
Combustio.....	12	4	10	3		2		1	3	1	1	2							26	13	39
Dermatitis herpetif.....							1												2	2	2
medicam.....				1		1					1								2	2	4
venenata.....							1								1				1	1	2
repens.....							1												3		3
Eczema.....	139	127	49	53	32	39	25	27	49	56	48	53	28	37	19	23	9	13	396	428	824
marginat.....						1		3					5		1		1		11		11
Epithelioma.....												1		1		2			3	3	6
Erysipelas.....					1		1	1	2	1	3								7	2	9
Erythema multif.....	1	1	1		1	2	1	1	1	2			1	1					6	7	13
nodos.....			2			1													2	1	3
Fibroma.....									2		1								3		3
Furunculus.....	2	3	1	2		1	4	3	7	3	5	5	1	2			2	1	22	20	42
Herpes simpl.....					1	3	1	1	1	2									3	6	9
zoster.....			1	2			2	1	2		1								6	4	10
tonsur. maculos.....					1		1	2	1		1	1							4	3	7
Hyperidrosis.....			1		1	1	2	2	1		1		2		1	1		1	7	7	14
Ichthyosis.....			3	1				1	3	1									4	2	6
Impetigo contag.....	54	51	38	39	9	22	2	3	3	6	4	5			2	1			109	127	236
Keloid.....											1		1						2		2
Lentigo.....					1		1	2											1	3	4
Lichen planus.....											2	1	3	1	1				6	2	8
urticatus.....	65	78	9	16		1		1											74	97	171
Lupus erythematos.....											2								2	2	2
vulgaris.....							1	1	1	2					1		2		3	5	8
Milium.....									1	1			2						1	5	6
Pediculosis.....	11	17	10	14	8	9	3	5		2			1						32	48	80
Pemphigus.....		3	1	1															4	7	11
Pruritus.....	2		3	5	1	1	4	1	11	9	16	15	10	5	4	5	14	6	65	47	112
Psoriasis.....		2	3	3	2	4	5	3	40	8	6	10	3	4	2	3	5	1	36	38	74
Purpura haemorrhagica.....							1		1										2		2
Raynaud's disease.....			1		2														3		3
Rosacea.....									1		2									3	3
Scabies.....	15	12	18	20	24	18	17	12	17	10	14	11	8	7	3	5	2		113	90	203
Sudamen.....	4	6	1	2	2	2	1	2		3	2	4		1		1			10	21	31
Syphiloderma.....			1		2		1	2	8	2	3	1							14	7	21
Tinea favosa.....			7	4	13	5													20	9	29
tonsurans.....	4	2	12	9	9	5		2	3		2								30	18	48
circinata.....	10	5	5	5	2	6			1		1	1							21	12	33
sycosis.....									4		8		3						15		15
versicolor.....					2		3	4	2	6	1	2							6	14	20
Urticaria.....	7	2	6	10	1	2	2	3	7	5	2	6	2	1		1			25	30	55
Ulcus cruris.....							1		1	2	4	7		5	6	2			15	21	36
Vaccinia.....	5	6	1	1															6	7	13
Varicella.....	3	4		1	1	1													4	6	10
Verruca.....			1	1	2	3	1	1		2	1								5	6	11
Vitiligo.....						1			1											2	2
																					2395
GENITO-URINARY DISEASES.																					
Gonorrhoea.....				2	1	4	32	5	41	4	8		4		1				87	15	102
Other G.-U. diseases.....	2		1				3		9		10		6		2		5		38		38
																					2535

generous donation of the transportation companies to their poor steerage passengers.

2. Comparing the statistics of my table with those of the returns of the American Dermatological Association for the years 1878-1893, I find that among the patients of the United Hebrew Charities Free Dispen-

sary the per centages of parasitic (with the exception of pediculosis) and neurotic diseases were larger; those of functional diseases and diseases due to derangements of internal organs smaller than in the returns of the American Dermatological Association.\*

\* Many atrophic and hypertrophic dermatoses tabulated in the returns of the A. D. A. are entirely absent here

Disease	Dispensary	A. D. A.
Acne and comedo . . . .	4.6%	9%
Herpes . . . . .	0.8	2.9
Lentigo . . . . .	0.002	0.1
Milium . . . . .	0.003	0.2
Eczema . . . . .	34.5	29.8
Pruritus . . . . .	4.6	2.0
Seabies . . . . .	8.5	4.05
Impetigo contagiosa..	9.7	2.19
Dermatomycoses : . . . .	6.5	4.8
Pediculosis . . . . .	2.9	3.7

The table speaks for more dire poverty among the patients of the United Hebrew Charities Dispensary than among the other poor of the United States. But it indicates also that in, spite of darkness, cold and starvations, they possess greater powers of resistance and are also more anxious to get rid of their parasites than the others.

4. A most striking illustration is the per centage of syphilis among the patients of the United Hebrew Charities Dispensary, 0.9 per cent as against 11.8 per cent in the returns of the Am. Derm. Ass'n, and this in spite of apparently more unfavorable conditions. At a time when the newspapers are publishing sensational "features" on the immorality of the masses and charity meetings are resounding with lamentations over the depravity of the poor, it is gratifying to show figures that compare so favorably with those relating to general society.

5. If this per centage is favorable as to numbers, a glance at the table shows the horrifying fact of participation of children in this roll of shame. Among the 21 cases of acquired syphilis recorded are three minors (one boy of 8 and two girls of 11 and 14 respectively,) while there was only one case over 40.† I believe there is a moral to be drawn from this appalling fact. While the older people are able to maintain their moral resistance, being safeguarded against immorality by religion, social conceptions and family ties imported from their former countries, the children born and raised in poverty and misery of new industrial conditions are deprived of the moral instincts which preserve the integrity of the parents. The most cruel

consequence of the factory and the sweat shop is not the dire poverty, to which these people are accustomed, but the imprisonment of the parents who are kept from implanting their instincts into their children. The nursery of morals is not the public school but the private home.

#### ECZEMA.

It is impossible to do any justice to the subject of the treatment of eczema in the scope of this paper. It is impossible to consider, even briefly, its different phases and varieties and their respective treatment. What I am able to do now is to set forth the general principles of the treatment of acute eczema, and this, too, in a fragmentary way only.

For the purpose of constructing an intelligent and comprehensive method of treatment of this mysterious disease, I accept dogmatically the following propositions:

1. Eczema is a parasitic disease.
2. It is a local disease of the upper layers of the skin.
3. It is caused by a micro-organism of a weak virulency, whose toxic effects are soon overcome by the skin under suitable and favorable conditions.
4. There is no specific for eczema, neither internal nor external.

Consequent on these propositions and on the clinical fact that eczema has a tendency to react on every irritation with exudation and more or less inflammation, it follows that:

1. The sole aim of internal medication can only be improvement of the patient's general constitution and of his functional activities with the hope to restore vital force to the system and to the affected skin, strengthening thus its resistance against the action of the microbes.

2. Inasmuch as external treatment intends to be causal it can only consist of applications of parasitocides; but in eczema as well as many other infectious diseases, in attacking the micro-organisms care must be taken not to injure the tissues in which they are imbedded.

3. Relating to acute eczema, all that our treatment is able to accomplish is to bring about conditions favorable for the natural

†Among the 102 cases of Gonorrhoea are one girl of 7 and one girl of 9, one boy of 11 and four girls between 10 and 15.

healing by removing injurious circumstances and suppressing unfavorable conditions which retard the natural tendency of healing.

The method of treatment and management of Acute Eczema based upon these propositions must naturally rest also on the principle of *non nocere*.

Still it is not a method of nihilism. It does not result in simple negation. On the contrary, it involves a system of active interference and of positive action.

It is a matter of daily observation that the eczematous skin is in a state of excessive irritability and of lowered resistance. The slightest injuries, which heretofore had no effect on the skin, as pressure of clothing, perspiration, exposure to heat, bring about aggravation of the diseases or new attacks. It is therefore our aim to preserve the skin from these injuries by covering and protection.

The prevailing symptom of acute eczema is that of inflammation, of hyperaemia, edema and discharge. The discharged fluid spreads over the surrounding healthy skin, macerating the epidemis and spreading the infection; or, when drying up into crusts, it remains on the diseased surface as a constant source of irritation. These conditions, too, can be eliminated by covering the skin with a suitable dressing. The dressing shall answer the following purposes: It shall protect the skin from external irritation, shall soften and dissolve the crusts and prevent their formation, shall reduce the exudation by an astringent action on the capillary system of the skin, shall possess antiparasitic properties to a degree permissible by the irritability of the skin, viz., shall destroy the microbes without injuring the epithelium, shall remove the subjective symptoms of the disease, the most troublesome of which is itching, and shall not disturb the natural tendency of the skin to exudation and casting off the microbes and the toxins by simply damming up the secretion but by eliminating its causes.

To comply with these requirements it is not only necessary to use the proper medica-

ments, but also to apply them in a proper way; or, in other words, the vehicles by which we carry the medicaments to the skin and the methods of their application are of the same if not greater importance than the drugs used. Taking into consideration the physical and physiologic properties of the vehicles commonly employed, it will become obvious that all the requirements above mentioned are fulfilled by having the applications in the form of powder or lotions, and that most of them are ignored when the coverings applied are ointments. I believe these remarks will serve a good purpose if they be reduced to this one point, to the accentuation of the fact that ointments are injurious in acute stages of eczema.

From all the requirements above mentioned, ointments meet only two; they cover the surface and macerate the crusts; but at the same time they macerate also the epithelium. They produce swelling of the horny cells, the effect of which is narrowing of the intercellular spaces and obstruction of the free exit of excretion, thus damming up the exudation and producing stasis of the mucous layers. Closing up the discharge, they prevent its evaporation. This diminishes the property of the skin to give up heat, increases its temperature and contributes to the increase of hyperaemia, edema and inflammation.

When the exudation is localized, viz., the eruption is papular or vesicular the covering shall consist of powder; good results also being obtained by glyco-gelatin pastes, pastes and lotions. But when the congestion becomes general, as in eczema madidans and also in eczema erythematousum, the dressing must be wet and of an astringent character for the purpose of macerating the crusts and to diminish the congestion promoting thus the natural process of normal cornification.

All these essentials are met by a preparation, which is largely used in Germany and which to my knowledge is very little known here. This medicament is Liq. Alumin. acet. or Liq. Burowii the preparation of which is given by the U. S. Dispensary, which is used in the preparation of 2 to 3 tablespoonfuls



to a glass of sterilized water. As a substitute one may use:

R Alumin. erud..... 5 0  
Plumb. acet..... 10 0  
Aq. destil.....500

Its action is astringent and antiseptic.

Other solutions of mild germicides may be used, as:

R Ichthyol .....5-10  
Aq. destil..... 100

Or:

R Acid. boric.....5-10  
Aq. destil..... 100

Dressings with these solutions or in combination with some indifferent powder (Lotions) are the best applications to the acute stages of eczema, care being taken to apply the dressing to the diseased surface only, avoiding unnecessary maceration of healthy skin.

In infantile eczema, especially of the scalp, I have used a lotion of ichthyol and carron oil 5 to 100. In eczema intertrigo painting the surface often with a solution of Arg. nitr. 2 to 3 per cent in addition.

To sum up, the main principles in the treatment of acute eczema are: (1) protection of the skin and (2) application of mild antiseptics. In the first the treatment is symptomatic, in the second it is casual. When the predominating symptom is that of exudation, the symptomatic treatment shall prevail.

With the subsidence of the acute exudative process and transition into the subacute or chronic stage, with the predominating symptom of disturbed epidermic function (formation of scales) or of cellular infiltration, stimulating pastes and ointments should be employed, stimulation being here equivalent to the use of parasitocides.

In chronic, eczema keratoides, especially in trades eczemas, of the hands, I have employed 1 to 2 per mille corrosive sublimate baths for 10 to 15 minutes as hot as the patient could stand, followed by applications of diachylon ointment containing 5 per cent. salicylic acid with satisfactory results.

The following data may be of interest:

The per centage of eczema in the total number of cases treated was 36 (against 29.75 per cent in the returns of the Am. Derm.

Assoc. and 33.12 per cent in the Dispensary practice of L. Duncan Bulkley.) The percentage of infantile eczema in the total number of all skin cases of children under five years was 40. These large percentages are to be explained by my grouping of seborrhea together with eczema. The prevalence of the disease in different months for the six years was:

	Children under 5	Children over 5 and Adults
January .....	33	61
February .....	23	33
March .....	28	49
April .....	21	40
May .....	23	47
June .....	19	49
July .....	19	45
August .....	20	57
September .....	22	34
October .....	25	52
November .....	17	46
December .....	16	45

#### PSORIASIS.

The frequency of cases in each month for 6 years was as follows:

January .....	6
February .....	11
March .....	12
April .....	7
May .....	7
June .....	4
July .....	3
August .....	4
September .....	3
October .....	7
November .....	4
December .....	6

The table shows almost twice as many cases in winter and spring as in summer and fall.

Contrary to the statement of many writers and more in accordance with English statistics, I have not found the disease more frequent in men than women. There is, on the contrary, a slight plurality of women in my table.

The occurrence of psoriasis in children deserves to be noted. Most internal clinicians state that psoriasis seldom occurs in the young. So Gerhard, in his system of Pediatrics, says that he has seldom seen

psoriasis in patients under five years of age. A. Jacobi states in his "Therapeutics of Infancy and Childhood" that for years he has seen only one case of psoriasis.

Cases of psoriasis in infants have been reported by dermatologists: Kaopsi in a child of 8 months, Neuman in a child of 4 months, Bateman in a child of 3 months. Rille reported three cases in children under 5 which he has seen in three years in the rich material of the Gratz Polielinic. Bulkley has seen among 366 cases of psoriasis only one case in a child under five, and six cases in children under 10 years of age.

The cases noted in my table in the column (0-5) were two girls, both aged 4; in the column (5-10) were one girl of 6, two boys of 6 and one boy of 7.

Twice have I observed the occurrence of the disease in members of the same family.

The treatment of psoriasis has not always been satisfactory. Internal medication has been of little avail. The old time-honored arsenic has often been found wanting. Some patients had taken bottles of Fowler's solution without any benefit, and when the eruption disappeared I never had the impression that the cure should be credited to arsenic. The local treatment is the one on which I have always relied. It consists, firstly, in thorough removal of the scales by oily applications, hot baths and brisk rubbing with *sapo viridis*, after which topical remedies are applied to the cleaned patches.

The remedies mostly used by me were chrysarobin for the body and ammoniated mercury for the head. But the more I used them the more cautious I became in their employment. In acute cases they aggravate the disease, in chronic cases they make things worse when stubbornly employed. The following case may serve as an illustration:

A boy of seven was brought to me with a relapsing psoriasis. He had his first attack four months previous and had been cured by internal medication and Naftalan ointments by his family physician. This time Naftalan was used again without effect. He presented a psoriasis guttata sparsely distributed over back of head, back, upper arms and legs. I prescribed Fowler's solution and

the use of 5 per cent chrysarobintraumaticin over the patches. They disappeared rapidly and the boy was seemingly cured. Three months later the boy was brought again to my office with a universal psoriasis involving the whole head, part of the forehead, inside and back of the ears and large areas over trunk and extremities, the character of the patches resembling very much those of seborrheic eczema. The mother reported that three weeks after I had discharged the patient a new spot appeared on the leg. She employed the same treatment herself, but the eruption kept on spreading. The more it spread the more industriously did she rub, in the chrysarobin, and the more she rubbed the more universal became the psoriasis.

From the experience with the disease one may deduce the following maxims:

1. Don't rely on arsenic as a specific against psoriasis. Do not commence the treatment with its administration and discard it after two weeks when there is no improvement to be noticed.
2. Chrysarobin and other strong skin stimulants awaken and support the natural tendencies to heal, but when there is no such natural tendency no stimulant will avail.
3. Leave all vigorous medication alone when the disease is in the stage of evolution, viz., when the patches are succulent and the base hyperaemic and raised. Use then indifferent or mild remedies, as sulphur or salicylic acid in weak percentages.
4. Retain chrysarobin only in chronic cases and disseminated eruptions.
5. In all cases be careful in giving your prognosis.

#### LICHEN URTICATUS.

I include a brief discussion of this disease because it is generally very little known, and yet is very often met with in general practice, especially among the children of the poorer classes.

Though recognized by dermatologists as a distinct disease and described by them under various names as *lichen urticatus* (Willan-Bateman) *lichen strophulus* (Casenave) *Prurigo infantilis* (Hutchinson) *prurigo simplex* (Brocq.) *prurigo temporanea* (Tomasoli,) it is seldom spoken of in text books

and even the most elaborate works on dermatology or pediatries give it only an honorable mention. And yet it is more widely spread than many other well-known dermatoses. Among the 2395 cases in my table, I find 171 cases of lichen urticatus, or over 7 per cent, and if only children under 5 years are considered, the percentage reaches the enormous figure of 24.

Lichen urticatus is a disease of children, preferably of the first five years of life; it is a disease of the poor, though occasionally I have seen it in children of well-to-do middle classes; it is a disease of the summer months; it is, in the majority of cases, an extremely chronic disease.

It starts with the appearance of a small, soft, rounded wheal in the center of which a minute vesicle appears which is soon broken or scratched off, evacuated of its clear serous contents and transformed into a solid and firm minute papule. The wheal is very evanescent; it disappears soon leaving the papule in its place as a lasting mark. Frequently the papules appear from the very start without transition from a vesicle, sometimes without precession of the wheal. This process goes on uninterruptedly. New wheals and resulting papules form before the first ones have disappeared, until in a short time the whole body, with the exception of the face is more or less covered with disseminated papules. The regions mostly attacked are the extremities on their extensor as well as flexor surfaces, the buttocks, the back and in severer cases also the abdomen and chest.

The papules are very minute, of the size of a pinhead and smaller to that of a hemp seed, of white color the flattened surface covered with thin and shiny epidermis, the smaller ones having frequently a little scale on the apex. They are often scratched off and excoriated. In older cases I found the whole skin of the body rough and pigmented as in prurigo. The papules are extremely itchy, especially at night, often depriving the child of its sleep.

The etiology of the disease is obscure. Uncleanliness and bites of insects have been accused, but I have often seen the disease in cleanly kept and well cared for children.

Dentition has been made responsible, but it is often seen in children not teething. Colcot Fox, the only dermatologist who has given a detailed description of the disease, based on 216 cases observed by him in the London hospitals (*Monatshefte für Dermatologie* 1890) regards the disease to be an abnormal irritability of the skin or an inherited or acquired disturbance in the equilibrium of the vaso-motor nerves, which leads to the effect that every external or internal irritation is followed by the production of a polymorphous disseminated eruption. Very often I noted the appearance of the disease after recovery from some febrile disease as scarlet fever, measles etc. or after vaccination.

The frequency of the disease in the various months for the six years was as follows:

January	4
February	9
March	10
April	13
May	30
June	34
July	22
August	19
September	16
October	6
November	7
December	1

The prevalence of the disease in C. Fox's cases was pretty much the same as in my cases. He gives the following table:

January	8
February	14
March	11
April	15
May	25
June	25
July	33
August	22
September	29
October	21
November	13
December	7

The treatment of the disease is not very satisfactory. Bathing in alkaline water I found beneficial in a great many cases, the bath having the temperature of the body and administered in the evening before putting the child to sleep. After gently wiping



the skin a lotion of Iethyol 5; zine earbon 10.0; Tale. 10.0; water 120.0; or, Acid earbol. 3 instead of ichtyol is mopped on, or if the skin is rough and thickened a paste of ichtyol 3.0, zine oxid 9.0, sulphur prae-cip. 6.0, Terr. siliceae 3.0, adip. benzoat 40.0 is rubbed into the skin. In old inveterate cases I have obtained good results from a mercurial ointment (Hydrarg. oxid. rubr. 1.0, sulphur sublim. 25.0, vaselin ad 100.0.)

Internally I have often been compelled to administer bromides to secure sleep for the unfortunate little patients. Where intestinal derangements were present I gave calomel and salol in small doses.

#### SYPHILODERMA.

The treatment that has been almost exclusively employed by me at the dispensary was inunction of blue ointment. Time forbids me to enter into a critical analysis of three standard methods of administering mercury, viz., (1) by the mouth; (2) hypodermic injections and (3) inunctions. I have discarded the first method mostly used in this country for the reason that in the majority of cases it is, insufficient in its therapeutic effect, as only a small, therapeutically insignificant amount of mercury will pass through the intestinal tract without causing toxic symptoms, and in a great many cases it is inefficient as a permanent cure. Most of the cases of relapsing syphilis which I have seen were treated in their first attack with protiodid pills. The second method (subcutaneous injections) was omitted on account of its accompanying and resulting pain, to which only few patients in public practice submit, and for the lack of time necessary to its employment. I have therefore treated my syphilitics exclusively by inunctions, which I have always found efficacious and reliable. For the last two years I have employed Welander's method of using the blue ointment with the most gratifying result.

Owing to the fact that this method was regrettably little spoken of in the American medical periodicals and that it is almost unknown to the majority of American physicians, I will briefly state its use:

Lead by experimental investigation of his own and other well known dermatologists, Welander, Professor in Stockholm, came to the conclusion that the mercurial ointment being rubbed in the skin does not enter into the body through the skin, but that its effect is due to inhaling its vapors through the mouth. The inunction treatment he has found to be nothing else than a vaporization or inhalation treatment. He therefore in an article published in *Picks Archiv.* in 1897, advised the use of his "Sackchen" or bag method. The method consists in abandoning the rubbing in of the ointment which is objectionable for so many reasons, and using instead a bag, made of linen, the inner side of which is covered with the blue ointment of which one to one and a half drachm is used each day, the bag being worn by the patient on his chest or back. His first report of the use of this method in 20 cases was followed in 1898 by a report of 400 cases in which this method was satisfactorily used. Since then other known clinicians have corroborated his favorable statements.

Appreciating the fact that increased warmth will increase the evaporation of mercury, I have used instead of a linen bag the thick flannel pieces sold in drug stores under the name of "chest protectors", had them lined with linen which was stitched to the flannel on three sides, leaving the upper edge open, forming thus a bag in the inside of which the lining was covered with one or two teaspoonfuls of blue ointment, spreading it thinly over the whole surface. The ointment is applied daily or every second day, according to patient and severity of case. It is obvious that this method is pleasanter, simpler and more comfortable than the disgusting and tiresome inunctions.

The method has some drawbacks. Some patients could not stand the excessive perspiration of the chest caused by the flannel, and a few irritable and nervous persons suffered from nausea caused by the inhalation of the ointment vapors. This can be remedied by washing the chest often and by the use of mercury-vasogen instead of the blue ointment, the lard of which decomposes when it gets old.

I have used this method in 28 cases in dispensary as well as in private practice and had very gratifying results. The syphilitic symptoms disappeared in from three to five weeks. Only in four cases have I had to discontinue this method and to resort to others.

#### IMPETIGO CONTAGIOSA.

Under this heading I have included all pustular dermatoses which are usually differentiated as impetigo simplex, impetigo contagiosa and ecthyma, as they all have the same characteristic points; the lesion being pustular, disseminated, sharply margined and infectious.

The treatment consists in removal of the crusts and in cleansing and disinfection of the affected places and their surroundings. Both requirements were usually met by application of a wet Liq. Alumin. acet. dressing. The suppuration stopped in a few days, the reddened basis turned pale and the lesions soon healed up, after which a zinc-sulphur paste was applied for some time. If the crusts were thick and stiff, I had them softened first with some oily application, such as 3 per cent carbolated oil, for 12 hours, after which cleaning with soap and hot water followed by dressings of Liq. Alumin. acet. If the pustules were discrete and in older children, I touched the bases of the pustules with a cotton carrier dipped in equal parts tinct. iodi. and carbolic acid, covering them afterwards with Lassar's paste. I found this procedure effective and abortive. In impetigo contagiosa of the head, where wet dressings could not well be applied, I gave an ointment containing red precipitate and sulphur (Hydrarg. oxid. rubr. 1.0, sulphur sublim. 25.0, vaselin ad 100.0.) In cases of extensive distribution where antiseptic dressings could not be well applied, I gave sublimate baths twice daily with good results. The disease is decidedly one of children. Among the 236 patients 174 were children under ten years of age.

The frequency of the disease in the different months for the six years was as follows:

January .....	18
February .....	15

March .....	21
April .....	12
May .....	11
June .....	25
July .....	24
August .....	28
September .....	25
October .....	30
November .....	11
December .....	15

#### THE DERMATOMYCOSES.

(a) *Tinea versicolor*. It is said that any irritative application will cure this, but it takes usually a few weeks to accomplish a cure, and relapses are frequent. The treatment I have employed is, I believe effective. It consists in mechanical removal of the scales with a scalpel, then rubbing in pure Lysol. One application is usually sufficient to effect a cure. In persons with tender skins it produces an artificial dermatitis which usually disappears soon under cover of Lassar's paste.

(b) *Tinea circinata*. This disease is equally easy to cure by application of some parasiticide and by rapid exfoliation of the horny layer. The drug mostly employed by me was acid. pyrogallie. in paste or ointments. The value of internal medication, as administration of tonics to anaemic individuals, as advised in some text books, I could not comprehend, for the ring worm disappears much earlier than the iron will come into the skin.

(c) *Favus and Tinea tonsurans*. The treatment of these diseases is tedious and often discouraging in public practice. A great many cases are obstinate to all methods of treatment. The strongest irritants were not able to attack the deep seated fungi Tinct. iodi., carbolic acid, chrysarobin, mercurial ointments, were without effect in rebellious cases. Brocq's mixture (acid. carbol., tinct. iodi., chloral hydrat. aa.) produced pain and slight swelling but no cure. Epilation, especially of the healthy hair around the diseased areas (Zone de protection) was difficult to practice.

From all the remedies employed in the treatment of these scalp diseases, I found iodine to have the best effect, employed not in alcoholic solution, but with lanolin as an

ointment. The crusts are softened with oily dressings for 24 hours, after which the head is washed with *sapo viridis* and hot water, dried, rubbed with alcohol, dried and the hair of the affected parts and a considerable zone around shaved off. The diseased areas are then rubbed vigorously with *Iodi puri* 3.0-5.0, Lanolin 30.0 twice a day and a cap of some impermeable tissue worn over the head.

In more obstinate cases I have employed Unna's method of air tight dressing modified in the following way:

After rubbing in the ointment in the manner just described, a ring of Unna's glyco-gelatin is painted around the patch, a round piece of oil silk is placed over it, adhering with its edges to the ring, and the whole surface covered with a fitting piece of gauze and another coat of glyco-gelatin. This dressing keeps a permanent layer of evaporated iodine over the diseased surface and facilitates the entrance of iodine gases into the hair follicles.

The mothers are instructed to use the ointment and change the dressing every day.

In some cases of *tinea tonsurans* I have observed an inflammatory edema of the patches, which become considerably swollen a condition known as *kerion*. In recent cases applications of *Liq. Alumin. acet.* quickly relieved the edema. In neglected cases subcutaneous abscesses developed. One case presented an abscess the size of a hen's egg which required surgical treatment.

#### A CASE OF GRIPPE INFECTION RESEMBLING PUERPERAL FEVER.\*

BY JOSEPH BRAYSHAW, M. D., HOMER.

If we are to judge by the literature of the past five years, we will be led to believe that infections which resemble or may be mistaken for puerperal fever are almost unknown. We might believe, that, in recent years at least, these simulating affections are mere medical curiosities.

In an examination of the literature for the above period as shown by the indices

of over thirty of the leading Medical Journals of America and Europe we are at once struck by the scarcity of literature on the above subject.

So far as I have been able to find in a fairly diligent search the only case reported of a disease resembling Puerperal fever is one of Appendicitis reported by Denslow Lewis in the April 1901 number of the Chicago Medical Recorder.

In his case there were chills and fever on the third day, which subsided in a few days. Over one month later the fever again arose and on the sixth day after this, operation was done for Appendicitis. At the close of his essay he clearly lays down the indications for treatment when he says: "It is needless to add that appendicitis when diagnosed should be operated immediately. Pregnancy, the puerperium and even the early stages of labor, far from constituting a contraindication for operative interference, show an additional danger from which the patient can only be safeguarded by prompt and effective surgical procedure."

Is it possible that a condition as common as the puerperal, should so rarely be accompanied by fevers other than when due to septic infection. Or have the cases failed to get into literature, or again has your essayist failed to find them?

Our text books tell us that there are some other febrile conditions which may accompany the puerperium, and I doubt if there are many men in the general practice of Medicine, who if their diagnoses are fairly correct, have passed through a single decade without finding one or more such cases.

Diagnosis—Since 1842 when Prof. Hodge in addressing his students displayed his fine rhetoric by saying: "The result of the whole discussion will, I trust, serve not only to exalt your views of the value and dignity of our profession, but to divest your minds of the overpowering dread that you can ever become, especially in women under the extremely interesting circumstances of gestation and parturition, the minister of evil—that you can ever convey, in any possible manner, a horrible virus, so destructive in its effects and so mysterious in its operations

\*Read at the 52d Annual Meeting, Quincy, May 21, 1902.



as that attributed to puerperal fever", and Meigs wrote "I prefer to attribute them to accidents or providence, of which I can form a conception, rather than to a contagion of which I cannot form any clear idea, at least as to this particular malady", and since 1843 when the immortal Dr. Oliver Wendell Holmes in his essay, entitled "Puerperal Fever as a private pestilence" forced home to the Medical profession the fact that they not only could be the carriers of a horrible virus but that they must use the greatest possible care to keep from being such carriers, such discussions as these have been forever stopped and the diagnosis has been placed on a firm basis, by the work of a few men who have spent their lives in the laboratories.

Clinically Puerperal fever and the conditions resembling it are too closely allied to be with any certainty diagnosed, but microscopically they are all different and here alone rests a positive diagnosis.

There may be, and usually are, certain physical signs which will serve as an indicator to the direction in which we are to look, and may even sometimes enable us to make a reasonably reliable diagnosis, but we are usually forced to remain in doubt until we find the specific virus.

Prognosis—I have no positive data on which to found this statement but it is my impression that the prognosis in these cases is even more unfavorable than in puerperal fever itself, and if recovery takes place it is after a long and tedious illness.

Treatment—The treatment in these conditions should be a sustaining one from the first combined with regular treatment of the accompanying disease, for there will be a prolonged sickness in a much weakened patient with the possibility of a septic infection at any time with the specific virus of the accompanying disease.

The case I have to report is that of a woman 35 years of age.

Family History:—The Mother and several Uncles and Aunts died of consumption.

Personal History:—Was delicate as a child and continued so as a woman, though was usually able to attend to her household dut-

ies, was supposed by her father, who is a physician, to be tubercular, though there are no positive signs, and tubercle bacilli have not been found.

Was the mother of two children nine and five years old respectively, had Grippe of moderate severity three times the last three winters.

Feb. 2nd was called to see patient first time, found medium sized woman, very anæmic and seven and one-half months pregnant. Bowels constipated, tongue slightly furred gray, said she had felt badly all day Friday, and stayed in bed most of Saturday (this was Sunday) aches all over and especially head and limbs. Had a tight and very persistent cough. Temperature at 9 A. M. 104.2, pulse 130, respiration 30. Physical examination showed some tenderness in lower and inner part of hypochondriac region, which patient said had been there for some weeks.

The uterine fundus was three finger breadths above the umbilicus and there was marked tympanites.

She had taken three doses of Epsom salts and a decoction of senna (quantity of either not known) ordered an enema but a syringe was not obtainable so gave tablets of Aloin  $\frac{1}{2}$  gr. Ext. Belladonna  $\frac{1}{8}$  gr. Strych. Sulph.  $\frac{1}{120}$  gr. and extract Cascara  $\frac{1}{4}$  gr. to be given two every three hours until six were taken or bowels acted.

Ordinarily I would have reduced the temperature by sponging but the house was very open and there was an extremely hard blizzard blowing and the walls seemed to offer no obstacle to the wind, so gave Acetanilid 3 gr. Soda Bicarb. 2 gr. Caffeine Citrate 1 gr. every two hours until seven P. M. when temperature had gone down to 102.2 but bowels had not acted and gave calomel and Soda Bicarbonate.

Feb. 3rd. 8 A. M. Temperature 101, pulse 120, respiration 26 aching very much decreased though present to some extent.

Cough has increased and become very aggravating, gave Dover powder sufficient to control it, and bowels not having acted ordered enema which brought away a moderate amount of fecal matter but the family not

thinking the bowels had acted sufficiently gave another dose of Epsom Salts without my orders and before my next visit.

About ten o'clock that night labor pains started which were not reported to me until the next morning at 7:30.

On Feb. 4th arrived about 8 A. M. and found head resting on the Perineum and child was born in about half an hour, found bones of skull soft, child weak and very anaemic (almost parchment white) and would not make any effort to breathe but was re-useitated by blowing in the mouth and still lives.

Placenta came away without difficulty. and there was not to exceed half an ounce of blood lost from both mother and placenta. Uterus contracted down properly.

After child was born (about 9:30 A. M.) temperature was 99.5 pulse 100, respiration 26. 5 P. M. bowels acted and passed a large amount of urine, temperature was 104.2, pulse 120, respiration 32.

Feb. 5th. Ever since the child was born she has complained of a drawing pain in the region of the right ovary and extending up to the region of the gall bladder every time the uterus contracted. Has a great amount of pain in muscles especially of chest and abdomen. Cough still somewhat annoying and brings up a moderate amount of mucus. Is very restless; bowels not acted and did not act during the entire sickness but very few times without either a cathartic or an enema. Temperature was from 101 to 103, pulse 120, respiration 26. Pain in muscles was relieved with acetanilid after which she rested fairly well.

Feb. 7th. The urine which had been normal in both quantity and quality was found to contain 1.1-2 per cent of albumen and was very scant in amount, was given a saline diuretic after which urine became normal in amount but still contained albumen. The temperature continued in the region of 100 and pulse from 120 to 124 and respiration from 20 to 24 until Feb. 9th tongue had cleaned off and the bowels and kidneys were acting better than at any previous time.

Sometimes during the night of the 8th she had felt a tearing sensation in the right side

since which time the pulling or drawing pain as she called it had been absent.

Feb. 9th, 9 A. M. Temperature 102, pulse 124 respiration 24, continuous pain in right ovarian region. Tympanites increased and complains of feeling short of breath, but looks bright. 3 P. M. Temperature 103.4 pulse 120, respiration 22 and at 6 P. M. temperature was 102.4 having been reduced by sponging. Tympanites increased, has anxious expression, is restless and has well marked delirium, I ordered enema of warm water and gave 1/30 gr. Strych. Sulph. every four hours.

Feb. 10. Condition about the same as yesterday except all the symptoms slightly relieved though pulse and respiration were increased in rapidity.

Feb. 11. Temperature, pulse and respiration unchanged. Cough loose and not very frequent, complains of pain in whole right side of abdomen and thorax. Pain on inspiration resembling pleurisy, there was crepitus over lower part of right lung.

Feb. 12. General condition unchanged except well marked effusion in right pleural cavity which was found to contain the bacillus of influenza and the peritoneal effusion was on the increase. Peritoneal fluid not examined; large amount of perspiration, Antiphlogistine was applied over abdomen after which inflammation seemed to subside.

The condition remained unchanged except the pleural effusion increased until aspiration seemed indicated on account of dyspnoea, but the father of the woman suggested a cantharidal blister which was applied after which the effusion slowly subsided.

Feb. 16. Morning temperature was normal, but the pulse was 120 and respiration 32, the effusion very noticeably decreased and the peritonitis was subsiding, the temperature run up to 100.4 in the evening, was normal the next morning, but at 6 P. M. was down to 97.7 the pulse and respiration continued rapid and temperature ranged between 99 and 100 until the 19th when it went up to 101 and she complained of pain in left ear, and on the 20th the tympanic membrane was incised and there was a discharge which contained the specific bacillus of grippe Pfeifer

and Kittasato after which the temperature was normal for twelve hours then it ranged between 99 and 99.5 until the 23rd when without any apparent cause it went up to 101, pulse 120, respiration 26.

Feb. 24. Temperature 101 to 102, pulse 128 and respiration 26 to 32, apex impulse not visible, first pulmonary sound accentuated and friction sounds in the precordium more noticeable during systole. Heart dullness normal in area.

Feb. 25. Heart dullness considerably enlarged, apex impulse neither seen nor felt. Temperature 100.5 to 102, pulse 124 to 132, respiration 22 to 34. Effusion about gone from right pleura but the upper lobe of the right lung was found to be filling up.

Feb 26. 9.00 A. M. Temperature 98.2, pulse 120, respiration 22. The pulse was regular but small in volume for the first time during the illness.

Heart dullness greatly enlarged extending one inch beyond the left nipple line and reaching to the third inter-space and one finger breadth to the right of the sternum; Dyspnoea extreme and there was marked cyanosis. At 9.45 A. M. the temperature was 97.8, pulse irregular and intermittent.

The father of the woman gave hypodermic of morphine sulphate  $\frac{1}{4}$  gr. and Atropin sulphate  $\frac{1}{100}$  gr. and pulse became more regular. Had I been doing this I should have given strychnine and digitalis, but I must confess that I believe there was a better result from morphine and atropin, for in a short time the pulse had become more regular and the patient seemed much relieved. Strychnine had been given all during the illness and digitalis was now begun in large doses. Pulse remained intermittent more or less all day and night, but next day became more regular and ceased to be intermittent but continued very small in volume.

The fluid was rapidly absorbed from the pericardium and resolution commenced in the right lung on the fifth day from the time when the pneumonia was first noticed and the secretions were brought up as a thick, creamy, semipurulent sputum which contained the bacillus of grippe, associated with the diplococcus of pneumonia.

There were no tubercle bacilli present so far as I was able to find, but there was elastic tissue. There were large numbers of eosinophiles in the sputum from the first.

The pulse remained better, and although it never got below 100 and was frequently as rapid as 120, the respiration became normal and temperature ranged from 97.4 to 98.7 and patient seemed to be in a fair way to recovery until March 13th after she had been sitting up from one to two hours each day.

On March 13th she had a chill after which the temperature went up to 104.5 and after this at intervals of from six to thirty-six hours had repeated chills with temperature ranging from 104.5 to 105.5 after chills, and from a little below normal to one above normal at other times.

The blood at this time showed a marked leucocytosis. (35,000 per C. M. M.) and was rather poor in hemaglobin. There were large numbers of irregular and crenated and a few nucleated red corpuscles.

This condition remained until the morning of March 22nd when after eating a more hearty breakfast than common she raised up in bed and suddenly dropped back dead.

There was no autopsy.

In the body of the paper I forgot to mention that there were the same characteristic bacillae in the pericardial fluid as in the other secretions.

During the whole illness there was no lochia except for a part of two days, one about six days after parturition and the other 24 days after.

The discharge (very scant in amount) was not offensive at either of these times and contained nothing which would give any indication of infection.

It was the only fluid examined which did not contain the bacillus of grippe.

It would have been interesting to have examined the peritoneal fluid, as it is my belief that the peritonitis came from a former inflammatory adhesion which had been broken down by the contraction of the uterus after labor.

I would add, that involution of the uterus, in spite of the illness progressed to almost the normal degree.



## AN UNUSUAL CASE OF TYPHOID FEVER.\*

BY J. W. KELLY, M. D., SPRINGFIELD.

So much has been written on typhoid fever, and it being a disease, the many complications of which, being familiar to you all that I will not attempt to report this case in detail but simply present it in substance.

The case is that of a young man H. F. age 18, clerk. I was called to see him on December 13, and found him quite ill with a high fever; history of rather sudden development; could not detect any of the characteristics of typhoid, so began the use of quinine which I continued for five days, when the disease gave the clinical signs of typhoid fever.

At this time (December 18), five days from the time I first saw him, I had him removed to the hospital and began the usual treatment, but fearing a malarial complication I continued the use of quinine for two days more; he had been receiving forty grains daily; at this time the rose spots appeared on the abdomen in large numbers.

December 20, (seventh day), he was unable to urinate, not having done so for twenty-four hours; I catheterized him at 9:30 A. M., and drew twenty-six ounces of urine, again eleven hours later thirty-one ounces by catheter; albumin a trace, and diazo reaction present. Highest temperature was 104, lowest, 100, pulse 90, respiration 30.

December 21, nothing of interest except forty-two ounces of urine in eighteen hours and one involuntary urination.

December 24, (eleventh day), temperature reached 104.6 at 10 A. M. pulse 120, and very weak; respiration 30, tongue swollen and raw looking, one involuntary urination and defecation and had one vomiting spell, and perspired excessively; the temperature had fallen to 99.2 by 11 P. M. December 26; fifty-two ounces of urine in thirteen hours about this time numerous small abscesses appeared and remained several weeks.

December 27, sixty-four ounces of urine in

twelve hours; the patient had been drinking, aside from the milk, one hundred ounces of water daily and was taking considerable calomel in small doses. December 28, (fifteenth day), at 12:45 P. M. temperature in the axilla was 106.1 pulse 122, respiration 28, was delirious and vomited watery fluid.

One hour later he had a chill lasting twenty minutes, pulse was very weak, and abdomen very tympanitic and only four ounces urine was voided in eight and one-half hours; at 7:20 he took another chill which was very severe, shook the furniture in the room, and lasted forty-five minutes. The temperature was taken after the chill and was found to be 107.6 in the axilla; the pulse was not taken, but one hour and a half later it was 80 and respiration was 34. Ten minutes later or 9 P. M. he vomited and bowels moved involuntarily and another slight chill immediately followed, making three chills in eight hours.

Until five days previous to this time he had an occasional light chill, and I examined the blood three times, but found no plasmodia; notwithstanding this I put him on forty grains of quinine and six grains of capsicum daily, and during the five days that he was taking these, no chills occurred until the day mentioned.

I then immediately increased the quinine and capsicum, and from 9 P. M. (the time of the last chill) until 6 o'clock on the following morning he had taken sixty grains of quinine and nine grains of capsicum and five drops of guaiacol and the temperature had fallen to 96, pulse 76 respiration 18.

Before the end of twenty-four hours he had taken one hundred grains of quinine and fifteen grains of capsicum; I continued this for five days, and increased the guaiacol three drops daily, until he was getting fifteen drops three times daily, when it was gradually reduced, he had no more chills except one light one late in the disease. During the few days following, he had an occasional involuntary passage of urine and feces, with a continuation of the delirium.

I might as well state right here that he remained delirious for about six weeks; one not knowing him would not recognize the

\*Read at the 52d Annual Meeting, Quincy, May 21, 1902.

delirium, but he would use profane language which he never used before or since that time; he also made an attack on me.

When his parents recognized his rational state of mind I found on quizzing him that he knew nothing of what had occurred during those six weeks.

December 31, (eighteenth day) at 7 A. M. the temperature was 98.2, pulse 88, respiration 20, there was slight epistaxis which occurred occasionally for the following four days during which time the temperature ranged from 99 to 102, voiding large quantities of urine and perspiring freely and sometimes excessively.

January 4, (twenty-second day). Up to this time the diet had been milk, broth, panopepton and globon; but on this morning I allowed some rice gruel and at 11:30 A. M. the temperature arose to 103.6, pulse 112, respiration 24 and he complained of a chilly sensation, and on the following day he had a slight chill which lasted for about fifteen minutes.

During this time he was taking quinine but not in such quantities as before mentioned, as at the end of five days it was gradually reduced.

From January 5 to January 8, the temperature was normal or below, and as patient's vitality was very low, I allowed some soft foods, and the temperature arose and ranged from 100 to 101.2 for one day, then fell back to normal for one day, and on the following day which was the twenty-eighth day of the disease it arose to 102 by 3 P. M. but by 10 P. M. it had fallen to 98.4. During these variations I did not withdraw the soft foods.

January 11, sixty ounces of urine in sixteen hours. From January 9 to January 14 the temperature was normal and pulse did not exceed 90, still patient remained delirious; at one time he screamed for an hour; occasional involuntary urination during this time.

January 15, (thirty-third day), 4:20 P. M. temperature 96, pulse 68, very weak and irregular; respiration 14; at 5:45 one hour and twenty-five minutes later, the temperature was 98.8, pulse 80, respiration 40, and perspiration was excessive; at 11 P. M.;

about five hours later, the pulse was so weak and irregular that the nurse could not count it; free perspiration continued throughout the night.

At 8 o'clock on the following morning, the pulse was again regular and of fair volume; from this time to the end, recovery was uninterrupted except the continuance of the delirium until he was nearly well; during this delirium occasional involuntary urination occurred; temperature often became subnormal, sometimes as low as 96.

Treatment in the main, was the usual treatment in such cases, but drugs were given much more freely than usual, because there were so many indications of their use; they consisted, aside from what has already mentioned, of strychnine, whiskey, digestives, sedatives in large quantities, calomel and other laxatives in good quantities, as there was a tendency to constipation through the entire course of the disease; intestinal antiseptics were given as indicated; Globon and panopepton were given for a long period.

All of these were given as indicated with only very little derangement of the stomach, which was somewhat surprising, as he had some chronic gastric derangement before he became sick.

Resume—The points of interest are:

- (1) Sudden development.
- (2) Hyperpyrexia which was controlled by quinine when no plasmodia were found in the blood.
- (3) Continued mental perversion which was, the greater part of the time unrecognizable by one not acquainted with him.
- (4) The marked variations in temperature.
- (5) The marked changes in pulse and respiration on the night of January 15 and 16.

#### CONSISTENCY IN MEDICAL PRACTICE.\*

BY J. N. NELMS, M. D., TAYLORVILLE.

This article is written in defense of the honest legitimate practice of medicine.

\*Read at the 52d Annual Meeting, Quincy, May 20, 1902.

In our preparation for the practice of medicine and surgery, we are governed by certain laws and restrictions. We must first give satisfactory evidence of having acquired some previous educational attainments, after which a graded course of four years duration is obligatory; during this course we must learn practical anatomy by dissections of the entire human body; we must study and master both physiology and pathology and be able to detect anatomical lesions of organs and tissues by clinical observations and microscopical examinations. We are not only required to diagnose but to successfully treat all characters of maladies.

We are taught in materia medica and therapeutics that certain drugs and chemicals have a decided physiological action and are classed according to their uses as cathartics astringents, stimulants, sedatives, diuretics, &c. Experience has taught us the efficacy of many preparations when properly administered.

Having exhausted our College curriculum, mastered the proposition of incompatibles and synergists and of therapeutics, so far at least as it is possible to do so, we embark upon our mission of duty and usefulness. No sooner have we fairly launched than we are compelled to compete with all manner of ignorant pretenders known as Osteopaths, Hydropaths, Magnetic Healers and Christian Scientists.

In our effort to rid ourselves of such competition, we resort to legislation and become objects of derision for the laity, who invariably sympathize with these so called victims of our relentless persecution. The laity as a rule, while well informed on most subjects, are comparatively ignorant on the subject of medicine. In our race for supremacy, and in our lack of ethical support for a fellow practitioner we lead the laity to discredit our sincerity and question our ability. A lack of stability in our methods, and our inability to successfully treat incurable maladies have caused them to grasp at the fictitious. As previously stated there is no longer any stability or permanency in our system of treatment. The methods employed today are condemned tomorrow. Our com-

promising attitude toward the Homeopath is a victory for Homeopathy; the adoption of Brand's method of reducing temperature to the exclusion of drugs is a signal victory in favor of Hydropathy; the employment of Massage to the exclusion of medication is giving aid and comfort to the friend of Osteopathy; the exclusive employment of Hypnotic suggestion is a conquest in favor of Christian Science.

We are guilty of all of the above misdeemeanors to our own detriment and disgrace. The adoption of the principles of Nihilism as it pertains to our profession is a fatal blow to our fraternity. If you have no faith in the efficacy of drugs, your patient will have no confidence in your employment of them; then who is to blame if they choose to accept erroneous ideas and worship false God's? In certain localities typhoid fever is treated exclusively by Brand's method in other localities this method is superceded by cold applications to the head alone; the physician makes his daily rounds only to advise them as to when to change the cloth on the patient's head. How long will it take the laity to observe that it does not require a professional to change the applications? How long before we will be compelled to compete with a new generation of physicians whose complete armamentarium consists of a clinical thermometer and a wet rag? I am an adherent to our former methods of employing drugs in the treatment of disease.

I believe in hygiene, sanitation and all known methods of prophylaxis. I do not claim that we have specifics for the treatment and cure of all diseases, but I hold that we possess remedies which will at least temporarily alleviate the majority of symptoms.

I further believe that the most rational methods of treatment consist in the judicious employment of medicines of a reliable strength and composition. We should not abandon a typhoid fever patient to his fate simply because his disease runs a tiresome self limited and tedious course; if we cannot control it as to time, we can at least mitigate the symptoms.

I am a believer in the efficacy of intestinal



antiseptics in typhoid fever. I do not employ them in accordance with any fixed rules, but as the indications demand. If properly employed, they prevent intestinal fermentation, avoid the evolution of gases and the consequent tympanites hemorrhage, and perforation. The question of the abortion of typhoid fever has been discussed pro and con. It has its supporters and its antagonists. Time will not permit me to enter into the discussion. Suffice it to say that my experience alone has taught me that we have every variety of typhoid fever from the mildest type to the most aggravated form, that the severity of the attack depends upon the amount of infection and the extent of the anatomical lesion. The extent of the invasion also depends upon the resisting power of the patient. Many cases of typhoid infection aided by the resisting power of the patient abort themselves. Then if we aid the resisting powers of the patient, assist him in eliminating the infection, we are at least entitled to a part of the credit. We frequently hear a physician say that his patient is threatened with typhoid fever. If the fever subsides at the end of the second or third week, it was only a threat. If it continue, it is the real thing and is diagnosed as typhoid fever. Typhoid fever germs do not threaten us at a distance. We either have them or we do not have them. If we have them it is typhoid fever, however mild the attack. If we do not have them it is not typhoid. In many cases the initial symptoms are violent. In the majority of cases, the onset is slow, the symptoms mild and the course brief. In all cases the disease progresses till the toxins succumb to the effect of the antitoxines, the time and result depending upon the extent of the lesion and the vitality of the patient.

At a recent meeting of a district society, some of our ablest members were heard to remark that the tendency of the times is toward Nihilism. Fellow Practitioners of the noblest profession on Earth, let me admonish you, let me sound the warning signal that this is dangerous territory and should be explored with the greatest of caution. Nihilism means nothingness and to

do nothing will in the estimation of the public put us in the attitude of know-nothingness.

In cases of sickness, the patient and friends expect us to do something; if our best energies are employed we are justified in a measure however the case may terminate, but if there be the slightest evidence of negligence on our part, we become the victims of public condemnation. Nihilism in medicine means the annihilation of the physician as a professional. I do not condemn massage, suggestion, hydrotherapy &c. except when employed as a substitute for the more potent and reliable remedies. They are extremely serviceable as adjuvants. A positive declaration that the patient is better when used as a suggestion in his presence brightens his prospects and frequently tides him over a critical period.

I had one man to remark that he did not believe that my patients could die if they desired to do so, that I would discourage such conduct and even talk him out of it. If the tendency is toward nihilism, and this be the correct principle, then the administration of drugs for the past ages and generations has been an outrage to humanity.

If Nihilism is to be the tendency in the future, why puzzle our brains with materia medica, therapeutics and chemists. If we are to discard drugs in the treatment of our most serious maladies, it will be much easier to dispense with them in the milder forms of disease. When this is done and sanctioned by the regular profession, how much different or better are we than the class of individuals whom we condemn, and against whom we seek to legislate? I must admit that drugs are dangerous weapons when in the hands of the ignorant just as implements of warfare are dangerous in the hands of an enemy. Drugs of a reliable strength in the hands of a competent physician are as safe and essential as the food we eat; in fact, more people suffer from overeating than from over medication.

Errors in diet in the period of what should be a well established convalescence are responsible for many fatalities. I was taught to believe that it is better on your

part to have your patient die from treatment than from neglect, on the theory that sins of omission are greater than those of commission.

Irregulars have the advantage of us in many regards; they are supposed to possess supernatural powers and can hold the confidence of the patient pending a new inspiration or revelation for a greater period of time; if the patients confidence begins to falter if a mutiny is imminent, they, like Moses, have only to reascend the mountain, make a visit to Kirksville and return with a new inspiration. Patients who demand instantaneous relief at our hands will patiently follow the instructions of an Osteopath for years with no apparent improvement. Why this is true can be explained only on the theory of superstition. He will take treatment at the hands of an irregular till his malady assumes a dangerous type, he is brought face to face with the grim monster; you are called to his assistance; by patience, skill and self sacrifice, you tide him through the critical period; as soon as his health will permit, he returns to his irregular and when time alone has fully erased all evidence of disease, he signs a testimonial that he has been permanently cured by a certain individual after having been abandoned to his fate by his family physician.

This is one of the most conspicuous examples of human inconsistency; the human family are both superstitious and credulous; the irregular by false promises and fraudulent practice arouses this credulity and secures their confidence, after which they are wholly within his power. Our ancestors were more skilfull and strategic than ourselves in enforcing upon the minds of their patients a belief in the necessity of administering drugs. If no pathological condition existed, placebos were employed to teach the patient that he must at least look to internal medication for relief.

I believe this is the proper course to pursue. If your patient does not need medicine, give him the benefit of all your powers at suggestion, hypnotism &c. and clinch his confidence in your ability with a placebo; in no wise sacrifice his confidence in you by

resorting to the irregular processes to the exclusion of drugs.

*When I am forced to meet irregulars on any compromise terms whatsoever by the abandonment of the best methods of treatment as I understand them, I hope that an honest conscience will condemn me as an imposter and a fraud of the most virulent type.*

Surgery has made vast improvement and advancement in recent years; this field of work has not been invaded by incompetents to the same extent as medicine.

Twenty years ago certain regions and cavities of the human anatomy were held as sacred premises; the surgeon's knife has recently invaded every known cavity and receptacle; no recess or passage is too intricate for surgical exploration; ribs are resected, the pericardium stitched and thoracic vessels successfully ligated.

The cranial cavity is invaded and supra and subdural hemorrhage arrested. The abdominal cavity is explored and stomach and kidneys extirpated. Hysterectomies and ovariectomies, both supra-pubic and vaginal have been successfully performed. I am loath to believe that scientific medicine has not kept pace with the tide of surgical advancement, and am neither willing nor ready to abandon this well begun work till it has reached the stage of perfection, or has so nearly approached this stage as to command the confidence of all intelligent people. The physician's armamentarium is more complete now than at any previous time in the world's history.

We have all varieties of standard preparations of a reliable strength convenient to dispense and palatable to administer. We have preparations that have stood the test for years, but in this age of medical progress, we should not fear or hesitate to accept the new; in fact, we should try all things and hold fast to that which is good. Serum therapy while yet in its infancy has wrought wonders in the therapeutic world, both as to curative and prophylactic results. The mildness of the epidemic of small-pox now prevalent throughout the civilized world testifies to the efficacy of successful vaccination. It was formerly held that children

born of immune parents were at least partially exempt from small-pox infection; it was later held that if the mother was rendered immune from an attack of small-pox that all subsequent offsprings would enjoy immunity in a degree. It has recently been observed that if both parents enjoy immunity by successful vaccination alone, that the offspring is partially immune. The fact that vaccination has recently been more successfully and more universally employed than ever before proves to my entire satisfaction its efficacy and explains the cause of the change of the variety of smallpox from the malignant to the modified form as now exemplified. *Serum therapy has clinched the manacles and pinioned the mandibles of the merciless dragon of diphtheria.* Greater fields of usefulness are open to it in the treatment of tetanus, erysipelas, pneumonia, typhoid fever, in fact it is difficult to mark its boundless limitations of usefulness.

In my opinion serum treatment will in time be of positive utility in all infectious disease of a self limited nature. I have no faith in its employment in tuberculosis for the reason that the toxins of tuberculosis never die from auto-infection. They never produce anti-toxines. The more populous the colony, the better they thrive till their victim yields to their invasion. All advancement in medical science must be made in the face of opposition and in the midst of an existing prejudice. A credulous and criticizing public; credulous as to superstition, incredulous and criticising as to the advancement of real science, incited by press reports as contained in our metropolitan papers are ever ready to condemn our most efficient and reliable remedies as in the case of the epidemic of tetanus in Camden for which the vaccine virus was in no way responsible. Attempts at criticism by incompetent personages are the worst character of inconsistencies with which we have to contend. To be consistent, we must adhere to our former traditions, investigate, discover, recommend and employ every possible means for the extermination of disease which is the greatest known enemy to human happiness. If we are true to our instincts

and honorable in our methods we can command the high esteem and honor to which we are justly entitled. The regular profession should amalgamate itself into one brotherhood of honest hearts engaged in the earnest pursuit of an exalted and legitimate purpose worthy of the support and confidence of all mankind.

When we have proven our worthiness and sincerity by our consistency, legislation in our behalf will be a natural consequence and easily acquired.

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### THE GENERAL PRACTITIONER AND HIS SURGERY.\*

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BY W. C. BOWERS, M. D., DECATUR.

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How strangely different is the study of medicine and surgery today and twenty years ago. Then anybody could become a doctor by three years of study, out of which only two terms of six months each need be spent in a Medical College listening to the same lectures the second term that were delivered the first. No very trying questions were asked about the student's degree of education, though a high one was held in great esteem.

A crude or finished drug was scarcely shown to a class in materia medica, the Microscope was seldom seen by the common student and then only to demonstrate a few Cancer cells that he could'n't see for the life of him.

Surgical cleanliness was not well understood by the best of men. A prominent surgeon being seen to hold instruments in his mouth while making further examination of a patient's wounds, and the attempt to associate bacteria with disease as cause and effect was subjected to the most relentless ridicule.

By a process of evolution medical education has come out of this to a higher plane. The length of time now required in a Medical College with nothing less than a common school education to start with, is calculated to make the general practitioner a comparatively able man to start with.

He who has not been back to school in

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\* Read at the 52d Annual Meeting, Quincy, May 21, 1902.



these twenty years, should go and learn how many fine things he is missing the use of because of the lack of modern training. Post-Graduate study is so beneficial to the Physician and through him to the public, that I am not sure but what compulsory study of this kind within certain limits would be proper.

The general practitioner should know several essentials well if he would *do well* the common surgery and the surgery of emergency that falls to his lot. He is apt to think that if he is not doing laparotomies or occasionally removing a gasserian ganglion that he is not doing any surgery. One should probably not do elective surgery on brain or abdominal organs until after prolonged study and training in such work. Of vastly more importance is it for him to care for an obstetric case, aseptically sew up vaginal and perineal tears intelligently or curette an abortion case properly. He should be able in diagnosis and prognosis and *well trained in Anaesthesia, Asepsis, and Surgical technique.* Ability in diagnosis depends on being thoroughly grounded in Anatomy and Pathology, and on the broadness of individual education.

Anaesthesia is scarcely less than a surgical procedure and is so important that no one should be allowed to graduate in medicine except he knows well how to give an anaesthetic, knows the symptoms of safety and the danger signals and how to meet them.

Perhaps the most important essential is how to prevent wound infection. Further it should be well known how to procure "absolute sterilization of everything coming in contact with the wound." Modern surgical Asepsis is only about ten years old and is something which we older practitioners unless we are practical and have kept well informed don't know much about.

It is important to know surgical technique but it is of greater importance to know the technique of rendering anything aseptic and of keeping it so during the using.

In obstetrical work a little observance determines a woeful neglect of asepsis. Each man should study out and put in practice a detailed plan of asepsis of everything com-

ing in contact with a woman in confinement. The doctor should in cases of threatened abortion or confinement use soap, hot water, hand-brush, nail-cleaner, and bichloride as freely as if about to do an abdominal section and after the cleaning the finger that is to enter the vagina should not come in contact with anything before using.

It is useless to think asepsis is well carried out if the examining hand, after a proper cleansing is wiped on the family towel handed you, or used to lift the bed clothes or remove a filthy rag from a patient's Vulva.

What could be the advantage and what the danger of giving an intrauterine douche in a short-time pregnancy, before any part of the conception had come away; or of introducing a sound into a Uterus three months pregnant after the membranes had spontaneously ruptured?

A pair of unboiled obstetrical forceps in a common unscalded wash bowl containing a half gallon of tepid water and a teaspoonful of carbolic acid would'nt be aseptic.

Here are two extremes of teaching: "As soon as labor is over and the patient has had time for a little rest the physician should make a careful inspection of the perineum, vulva, vaginal and cervical tissue and if any laceration of the parts are found they should be at once repaired." (Wiggin.) This might do in a hospital with perfect aseptic possibilities but with a busy physician would be unsafe because of the inability to have every thing absolutely aseptic and from lack of trained assistance.

The other extreme is: "Never introduce your finger into the vagina after a labor unless a complication makes it necessary." (Ramdohr.) If one examines a perineal laceration by finger and then by sight, the latter being the only certain way, he will be atonished at the greater apparent necessity of suturing.

The following cases will illustrate to some extent the surgery that falls into the hands of the physician in general practice.

Case 1. A nursing male child fifteen months old, normal in every respect, was supposed to have in some unknown manner broken his arm and I was called to adjust the fracture. He kept his arm to the side

and would not allow himself or his arm moved. What manipulations and observations I made caused me to doubt both fracture and dislocation. I gave a drop of laudanum to the child and in half an hour he became relaxed and the arm could be moved normally. No injury was found. The trouble must have been rheumatism about the shoulder.

Case 2. Mrs. W. Mc. aged sixty-five, a small strong hard-working woman came under my care for a few days during her physician's absence in June 1900. She had not had any illness for years but gave history of broken leg a few years previous from kick of a cow. This healed normally. Of late felt weak and had loss of appetite, flesh and strength. Some fever showed at times and some mild pelvic pains. The uterus was smooth and pyriform in shape, movable, slightly tender and about the size of one five months pregnant. There was a slightly offensive moderate yellowish vaginal discharge but no blood since the menopause. Cervix bled easily but was not badly inflamed and contained no nodules. The supposition was that this was a sarcoma of the body of the uterus. In a case presenting some similarity but in a younger woman a *sarcomatous uterus* was mistaken for a *pregnant one* by a prominent French surgeon in February 1902. If I had a sound with me perhaps I could have cleared up a doubtful case. A few weeks later her attendant Dr. W. P. Davidson of La Plae, Ill. thought he saw matter oozing from the cervix, passed a probe and got deluged with pus. The woman recovered rapidly and has worked hard ever since though there was a second moderate accumulation of pus.

Case 3. Eddie M. aged eleven, white, single, full weight, and normal height, just out of the hospital following laparotomy for bullet wound of the abdomen, jumped on a moving train July 19th, 1900, and had his feet injured by the wheels. The sole of the right foot was ground to pulp and full of cinders and all the toes except the large toe were stripped of flesh. The sole of the left foot was ground off to its middle and the wound filled with cinders. Shoek

was not very severe but vomiting of some food occurred.

Drs. Jones and W. J. Chenoweth were with me in this case and we amputated the right foot above the ankle to get above any possible danger of sloughing. An esmarch bandage was used and rubber tubing tied above the knee. After loosening the tubing no bleeding occurred and could not be made to appear by any means. The arteries were searched for but not found. The circular flap was folded about the end of the stump and at the suggestion of Dr. Chenoweth a sterilized gauze bandage was wrapped about the stump in such a manner as to interfere with active hemorrhage by pressure and a common dressing placed over it. No oozing, no hemorrhage and no pus was ever seen about the dressings or the wound.

The dressing was changed in about a week and the wound was almost completely healed with a nice firm pad of flesh over the end of the bone. The other foot was thoroughly cleansed but not all the cinders could be removed, useless shreds were cut away and a few stitches put in where any advantage. Plain gauze wet in Boric Acid solution was applied and the solution very warm soaked into the dressings every four hours and bichloride solution 1/4000 once a day. The dressing was changed on the fourth day, gravel and cinders removed and the same dressing reapplied as the wound had kept sweet and clean. At the end of a week iodoform was substituted for the boric acid solution and the wound scarred over rapidly. He is now in the Manual Training School at Glenwood, Ill. learning the blacksmith trade.

Case 4. Mrs. Fannie W. aged twenty-one and normal in all respects shot herself with a 32 calibre bullet in the left side about 7th rib near nipple line July 24th, 1899, the ball striking whalebone was deflected upward and to left. The rib was probably not broken as there was no increased mobility or crepitus. The wound extended to the rib but the most persistent effort failed to reveal an opening into the chest cavity. There was no external hemorrhage and no certain signs of inter-

nal hemorrhage. Recovery advanced rapidly for a week when there developed a pleurisy making it probable that the bullet and possibly some clothing was in chest cavity. In another week chills, fever, sweats, pain, increasing weakness and loss of flesh, dullness on percussion and limited movement of chest were in evidence. As the dullness was limited and its line would not change by changing the position of the patient and heart about normally situated, the abscess was supposed to be walled off from the pleural cavity.

Between the 10th and 18th of August the aspirator needle was used several times before pus was located when a few whiffs of chloroform was given, the skin slipped up a little to make a valve, a bistoury was thrust between the 6th and 7th ribs three inches to left of original scar and a cut two inches long made which let large amount of pus out. The cavity was irrigated with boric acid solution, a drainage tube introduced and plenty of dressings put on. The drainage tube hurt her so much that I took it out and syringed the cavity out every other day until discharge about ceased. The cut healed before abscess was well and had to be reopened and was kept open by passing a clean probe into it every day. A full recovery ensued.

Case 5. Valentine S. a tall spare, but healthy looking farmer seventy years old driving in a dairy wagon when the team ran away and by some means doubled the man up in a corner of the wagon and broke his neck. Many bruises and abrasions were found on different parts of his body and quite a large prominence on the back of his neck opposite the 3rd or 4th cervical vertebra. The symptoms were numbness and distress but no positive paralysis. I was called to see the case with Dr. Godfrey of Mowequa and with him, Dr. Spalding of Mowequa and Dr. Foxworthy, an army surgeon. We made a careful examination of the injury. The opinion was unanimous that we had a fracture of the arch of the third or fourth cervical vertebra. By gentle but firm extension of the head and manipulation of the protuberance, I succeeded in reducing the displaced piece without accident. As

no symptom of injury of the cord from spicula of bone or from pressure showed themselves, the treatment was by the simplest external means. Pressure was maintained by position and the use of a sand-bag under the neck. Patient's convalescence was uneventful and recovery complete.

Case 6. Mrs. E. E. D. aged twenty, a small plump robust woman, commenced her labor in the morning with chills, head R. O. P. The labor seemed tedious, the pains were severe and the sac ruptured spontaneously about noon. The labor was laborious until 4 P. M. when pains became ineffective and the forceps were applied under chloroform. Asepsis was a special feature all the way through this case. The head was firmly packed in the pelvis in a posterior position and much force was required to dislodge it. The delivery occupied about a half an hour and wound up with a tear 1 1/2 inches up the rectum which was due to the posterior position and disproportionate size of the head. The septum was sewed with a continuous silk suture, avoiding the rectal mucous membrane, and under constant irrigation with salt solution. The first stitch was tied with a plain double knot and when the skin was reached the thread was carried once deeply around the ends of the torn Sphincter, drawn snug and anchored in the skin a half inch from the anus. Two interrupted sutures further took up the sphincter ends, then interrupted suture enclosing much tissue were used in the vaginal rent and a few in the skin completed the work. The urine was drawn every six hours, after antiseptic douching of the vagina, a boracetanilid powder dusted on and a clean pad applied. Nothing but water or broth was taken for five days and an opiate moderately to bind the bowels, when a castor oil and Rochelle salts mixture was given and a pint of olive oil injected into the rectum resulting in an early action. The bowels were then kept free with laxatives and solid food given. The catheter habit bothered about a week. The sutures were removed about the 14th day. The suture of the septum was drawn out as far as possible and cut off. No trouble resulted from the knot. The result in the case was all that should be desired.



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The Official Organ of the State Medical Society.

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Perry County—J. W. Smith, M. D., Pinckneyville.  
Pike County—R. H. Main, M. D., Barry.

Pope County—W. S. Dixon, M. D., Rosebud.  
Pulaski County—Chas. J. Boswell, M. D., Beechwood.  
Randolph County—H. C. Adderly, M. D., Chester.  
Richland County—M. E. Poland, M. D., Olney.  
Rock Island County—G. L. Eyster, M. D., Rock Island.  
Saline County—J. R. Baker, M. D., Harrisburg.  
Sangamon County—P. L. Taylor, M. D., Springfield.  
Schuyler County—A. W. Ball, M. D., Rushville.  
Scott County—J. P. Campbell, M. D., Winchester.  
Shelby County—A. G. Mizell, M. D., Shelbyville.  
Stark County—M. T. Ward, M. D., Toulon.  
Stephenson County—R. J. Burns, M. D., Freeport.  
St. Clair County—B. Portuondo, M. D., Belleville.  
St. Clair County—C. W. Lillie, M. D., East St. Louis.  
Tazewell County—C. G. Muehlman, M. D., Pekin.  
Union County—T. Lee Agnew, M. D., Anna.  
Vermilion County—E. E. Clark, M. D., Danville.  
Wabash County—J. B. Maxwell, M. D., Mt. Carmel.  
Warren County—W. H. Wells, M. D., Monmouth.  
Washington County—J. J. Trout, M. D., Nashville.  
Whiteside County—P. F. Purdue, M. D., Lyndon.  
White County—W. A. Steele, M. D., Carmi.  
Will County—Harry A. Patterson, M. D., Joliet.  
Williamson County—G. W. Evans, M. D., Marion.  
Winnebago County—S. R. Catlin, M. D., Rockford.

## DISTRICT SOCIETIES.

Aesculapian—H. McKennan, M. D., Paris.  
Brainerd District—J. L. Lowrie, M. D., Lincoln.  
Central Illinois—F. J. Eberspacher, M. D., Pana.  
Galva District—C. W. Hall, M. D., Kewanee.  
Fox River Valley (Kane and McHenry Counties)—F. H. Jenks, M. D., Aurora.  
Military Tract—C. B. Horrell, M. D., Galesburg.  
North Central—Geo. A. Dicus, M. D., Streator.  
Southern Illinois—E. E. Fyke, M. D., Olney.  
Tri-County—Leroy Jones, M. D., Hoopeston.  
Western Illinois—H. A. Chapin, M. D., Whitehall.

## COOK COUNTY SOCIETIES.

Chicago Medical Society—F. X. Walls, M. D.  
AuxPlaines Medical—W. R. Livingston, M. D., Maywood.  
Evanston—M. G. McEwen, M. D.  
Gynaecological—R. W. Holmes, M. D.  
Laryngological and Climatological—J. E. Rhodes, M. D.  
Neurological—C. H. Lodor, M. D.  
North Shore—Geo. E. Baxter, M. D.  
North Side—Mortimer Frank, M. D.  
Orthopedic—Edwin W. Ryerson, M. D.  
Pathological—Geo. H. Weaver, M. D.  
Pediatric—Emma M. Moore, M. D.  
Physician's Club—L. H. Mettler, M. D.  
Southwestern—Thos. J. McGonagle, M. D.  
Southern—W. S. Harpole, M. D.  
Stock Yards—R. J. Tiven, M. D.  
Surgical—A. E. Halstead, M. D.

All communications should be addressed to the Editor, 522 Capitol Ave., Springfield, Illinois.

The JOURNAL is published monthly. The subscription price is \$3.00 per annum in advance.

APRIL, 1903.

## THE NEW LAW.

Altogether the most important business engaging the attention of the profession of Illinois during the month of March or for many years for that matter, has been the effort of the Legislative Committee on behalf of the State Society to secure the passage of the proposed law printed in the last issue of the Journal. The committee after long and arduous labor in preparing the law had it introduced in the Senate on March 11, by the Hon. Dr. Watson,

where it became known as Bill No. 370, and in the House on the same date by Hon. Dr. Wheeler where it became known as Bill No. 626. The committee endeavored in drafting the bill; in having it introduced by a Republican in one branch of the Legislature and by a Democrat in the other; and in their arguments at all times and places to establish the fact that the Board was to be a strictly scientific and non-partisan organization. It was only after the highest legal authority had been consulted

as to the constitutionality of the second and third sections that they were urged for adoption. Here the committee came into conflict with the Governor's ideas of what the law should be and accordingly the law when up for second reading in the Senate was amended by the committee and on motion of Mr. Juul to read: Sec. 2. "The members of said board *may* be appointed etc., and Sec. 3 The Governor *may in his discretion* appoint etc. The words in italics indicate the changes made to heal the objections of the executive. A number of other amendments were made of which we do not here speak because of lack of space. The ideas of the Society were embodied in brief in the following editorial which appeared Monday, March 30, in the Illinois State Journal and the ideas of Governor Yates are embodied in *extenso* in an editorial which appeared in the same Journal Wednesday, April 1st. It is somewhat unfortunate that the writer of the editorial has seen fit to compare the laws proposed by the medical and dental professions with a law providing for the appointment of a board of examiners of commission merchants. This latter law, as we understand it, *vested the appointment of these examiners in five incorporated societies of commission merchants*. The professional laws assume only to *suggest the names of a number of competent men* to the Governor from whom he might appoint to office such men as might seem to him most worthy. The incorporated medical societies do not seek a law which can be compared with the law passed upon by the Supreme Court, and quoted in the editorial. We hope our readers will secure a copy of the law cited and the decision of the Supreme Court and verify these statements.

There are some other unfortunate comparisons made by the editorial writer which we may refer to later.

#### EDITORIAL REPRESENTING THE VIEWS OF THE STATE SOCIETY.

##### Medical Examiners.

One of the important and worthy measures before the present session of the general assembly is the bill proposed by the Illinois State Medical Society creating a board of medical

examiners. The bill is the result of a desire on the part of the profession to advance still further the standard of medical education and practice in the state. The board is to be non-partisan, will not involve any expense to the state, will permit the State Board of Health to devote its energies to sanitary subjects and is demanded by a large body of our most intelligent citizens. The State Journal hopes it will receive favorable action at the hands of the general assembly.

Rejoinder to above editorial presumably embodying the views of Governor Yates.

#### Bills May Be Vetoed.

Two bills are reasonably sure of being vetoed by the governor, if they pass in their present shape; and the worst of it is that, in many respects, they are excellent bills which the governor does not desire to veto.

One is senate bill No. 158, introduced by Senator Clark, revising the law in regard to the board of state dental examiners. The law on this subject now provides for a board of five members, to be appointed by the governor, by and with the advice and consent of the senate. The new bill was intended simply to promote and protect the practice of dentistry throughout the state, and to that end embraced several new restrictions; but when its counterpart was introduced in the house, Representative Rinaker, during the consideration of the bill in committee, proposed an amendment to the effect that the examiners be appointed from a list selected by the State Dental association. It is understood that Mr. Rinaker's idea was that the bill was of interest only to practicing dentists, and that accordingly it was right that they should suggest the board. The bill has not yet come to a vote in either house.

Another bill affected is the bill providing for the creation of a board of medical examiners, the chief object of the bill being to relieve the state board of health from the onerous duty of examining applicants for certificates as doctors of medicine, and to permit the board to devote its energies to the prevention and stamping out of diseases and contagion, and to inspecting and supervising sanitary conditions throughout the state and to its other numerous duties. As introduced, however, the bill provides that the members of the board shall be appointed by the governor from a list selected by the incorporated medical societies of the state. It is the understanding that the language of the particular section governing this point will be modified so as to provide that the governor, in his discretion, may appoint from such a list; but no formal action to this effect has yet been taken.

The governor, as a matter of principle, is opposed to both of these bills as they now stand. He is satisfied that the constitutional provisions requiring officers to be either elected by the people, or appointed by the governor by and with the consent and advice of the senate, are positive, and cannot be annulled or modified. The constitution expressly prohibits the general assembly from appointing any state officer whatever. Action by the general as-



sembly, in dictating by statute who shall be appointed, and who shall not, is indirectly an appointment by the general assembly, and therefore unconstitutional. The most serious objection, however, is not that the legislature would practically be making the appointment, but that the appointment of state officers in these instances would be made by incorporated societies. In other words, the governor is opposed to "government by society."

There has been quite a tendency in recent years to pass laws providing that this or that board must be appointed from this or that list of nominations furnished by this or that society. For instance, the pharmacy law provides that the state board of pharmacy may be appointed by the governor from among the registered pharmacists of the state, who shall prepare a list of nominations. It is the conclusion not only of the governor, but of many others, who have given thought to the matter, that the appointment of boards in this way is not for the best interests of the State. This is because members of boards thus appointed do not sustain the same intimate relation to the state and the executive and legislative departments as other boards, and accordingly have not the same feeling which arises from direct connection with the executive and law-making power—in other words, have no feeling that they are state officers, or representatives of the commonwealth. It is a fact not generally commented upon, but not concealed, that recently the governor came very near to removing the entire state board of pharmacy, for having employed without any consultation with anybody, an agent not provided for by any appropriation, and not named in any payroll or report, to act as an inspector and collector of statutory fees, for that department. The first that the governor or anybody else knew about it, was the discovery of the fact that the agent was a defaulter, and indicted. There is little doubt that had the board consulted with the governor about this appointment, there would have been a good appointment. So much as to the question of public policy.

On the legal point involved, the governor seems to be very clearly sustained by the case of *Charles W. Lasher vs. People of the state of Illinois*, and *Edward C. Reichwald et al vs. People of the state of Illinois*, decided by the supreme court of Illinois in 1899, and reported in 183 Ill. Reports, page 226. In this case the supreme court had under consideration a law which provided for the appointment of a board of examiners of commission merchants, to consist of five men to be named by five incorporated societies, among which was the Butter and Cheese Exchange. The supreme court held that the appointment of a state officer or a state board was a franchise which could not be granted to corporations, under Section 22 of Article VI of the constitution. This section of the constitution specifically states that the general assembly shall not pass local or special laws granting to any corporation, association or individual any special or exclusive privilege, immunity or franchise whatever.

There can only be one side to this question, and that is the position taken by the governor. "Government by society" is just as objectionable and unAmerican and unconstitutional as "government by injunction," or, for that matter, "government by legal opinion." Officers should either be elected by the people, or appointed by the governor, subject to confirmation by the senate. If incorporated professional societies distrust the motives of the governor and the general assembly, then let them propose in their bills for elections by the people. It is a great pity that bills containing many excellent and wise provisions, such as the dental and medical examiner acts, should be endangered and rendered void by such unwise and illegal provisions.

#### PROGRAM OF THE FIFTY-THIRD ANNUAL MEETING.

On pages 753-759 will be found the preliminary announcement of the committee of arrangements and the program for the approaching meeting. It is hardly necessary for us to say that all arrangements have been perfected to the minutest detail. The character of the committee and the location of the meeting insures this. Chicago and her medical men have had a wide experience in preparing for meetings and this promises to be the largest and most interesting which has ever assembled in her borders. The feast has been prepared and only awaits the guests to enjoy it. That the latter will come in large number we have every reason to believe.

\* \* \* \* \*

The program is so full that it will require the utmost industry and promptness to carry it out. We would advise the readers of papers to be on hand when the time for them arrives as otherwise, according to custom, the essayists will be compelled to wait until the remainder of the program has been completed.

\* \* \* \* \*

We have before suggested that it might be well to form a section on diseases of the eye, ear, nose and throat. This idea suggests itself again on a review of the program in which we find no less than eighteen papers bearing on these subjects. Of course it is desirable for many reasons to have all the members hear the reading and discussion of these papers. But since it is manifestly impossible for all those in attendance to hear all the papers, the Soc-



ity being already divided into three sections, there would seem to be no good reason why there should not be a new section created to be attended by all those interested in these subjects.

\* \* \* \* \*

As usual a reduced rate for the meeting will be given by the railways. It will be necessary for the members to secure a certificate from the local ticket agent at the starting point which should be turned over to secretary Weis upon arrival in Chicago.

\* \* \* \* \*

Those members who are not familiar with the city will do well to arrange to reach the city in the day time and take a bus or cab directly to Tremont Temple, Dearborn and Lake Streets where the committee will see that they secure proper accommodations.

\* \* \* \* \*

Finally we wish to ask the members to be faithful in their attendance at all the sessions of the Society. Ample time will be given to see the sights medical and otherwise each afternoon and several evenings so that there will be no excuse for running around.

\* \* \* \* \*

The May Journal will be issued on or about April 20th and will contain the program and all abstracts complete. We hope those essayists who have not yet furnished abstracts will communicate with Secretaries Abt and De Lee promptly.

#### CONCERNING DISEASE OF THE PANCREAS

There is reason for self-congratulation over the large part played by Americans in developing knowledge of the pancreas and its diseases. The beginning of a general appreciation of the clinical features of the various forms of acute pancreatitis may be said to date from the Middleton Goldsmith lecture delivered by Reginald H. Fitz of Boston before the New York Pathological Society in 1889.

Previous to this Senn had performed many experiments upon the pancreas in animals and among other facts ascertained that the secretion of this gland causes no peritonitis. Following this period a time intervened dur-

ing which the necroses in the adipose tissue concomitant with pancreatic disease obtained recognition and their connection with the latter was determined.

Notwithstanding the distinct position occupied by acute pancreatitis in clinical medicine, the recognition of its existence during life is still difficult and frequently an incorrect diagnosis is rectified by finding the alterations in the pancreas at post mortem examinations. Often the disease is recognized *intra vitam* by exploratory laparotomies and some of the first cases reported of recovery from suppurative and gangrenous pancreatitis following operative procedures have been reported by Americans.

McArthur reported a case to the Chicago Medical Society in 1889 of recovery following operation and in the report by Thayer six years later the claim was made that his case, operated upon by Finney was the first instance of correct diagnosis during life and the second of recovery. The case of McArthur and that of Walsh (1) of Colorado, however, make Thayer's case the third; it is noticed that all these cases are reported by American observers.

Of much more significance is the work of American investigators upon the etiology of acute pancreatitis and its relation to the disseminated necroses in the peripancreatic adipose tissue. Foremost among the numerous contributions to this phase of the subject is the proof by Opie that all the alterations encountered in man in acute pancreatitis may be reproduced in animals by the injection of bile into the pancreas; from experiments and the records showing an association of cholelithiasis and acute pancreatitis, and from some personal observations he has left the conclusion which must be disproven before any other view will be equally acceptable, that in many cases at least, the *raison d'être* of acute pancreatitis is obstruction of the mouth of the pancreatic and common bile duct in the diverticulum of Vater and the passage of bile into the pancreas by way of its ducts.

The manifold experiments of Flexner upon acute pancreatitis were already reported or

(1) Med. News, Phil., 1893, LXIII, 737.

completed before the work of Opie finished this important stage in the discovery of a definite cause for the disease. The work of Opie was no doubt instigated by that of Flexner. Flexner very ingeniously determined the presence of a fat-splitting ferment in the focal lesions of necrosis by treating a neutral fat prepared from butter with material from the small areas of necrosis. Although the fact that the lesions known as acute disseminated fat necrosis—and which are so commonly mistaken by operators for miliary tubercles—were in all likelihood due to the liberation of the pancreatic secretion into the abdominal cavity, was pointed out by foreign observers, its final determination has been established by the work of investigators in this country.

Among the recent publications bearing upon the subject is that of Wells (2) who has succeeded in producing typical lesions of fat necrosis in animals by the use of the ordinary commercial preparations of "pancreatin." The process whereby the characteristic white areas are formed in the fatty tissue of the omentum, mesentery and sub-peritoneal regions seems to be one of digestion and the active agent, the lipolytic ferment formed by the pancreas, steapsin. The peculiar distribution of the lesions, their focal character, is ascribed by Wells to the folds and irregularities of surface which allow of only certain spots or areas coming in contact with the secretion of the pancreas. When cotton saturated with "pancreatin" solutions was spread out over the surface of the omentum in animals so that all parts came in contact with the solution, the necrosis or fat splitting in the adipose tissue assumed a diffuse type.

It is gratifying that this last contribution to disease of the pancreas is also by an American investigator.

(2) Jour. Med. Research, 1903, IX, 70.

The twenty-fifth anniversary of the opening of St. Francis Hospital. Peoria was celebrated March 24-25-26, 1903. This community of nursing sisters was driven from Germany in 1875 during the Cultur-Kampf. The political crime of Bismarck has proven

a great blessing to the sisters themselves as well as to the middle west where this and other orders similarly exiled have taken up their beneficial work. Starting from Peoria as the mother house a number of hospitals have been established in Illinois, Iowa, Wisconsin and Michigan. The celebration was closed by a banquet given to the members of the hospital staff. The hospital is located on a commanding bluff overlooking the city and the beautiful river. It is a gem of architectural beauty. We hope the future work of the Institution will be as successful and beneficent as it seems to have been in the past.

Mortality Statistics of Illinois Cities for January 1903.

	Popul- ation.	Death Rate.	Diph- theria.	Scarlet Fever.	Measles.	Small- pox.	Typhoid Fever.
Chicago .....	1,885,000	18.30	50	33	21	11	54
Springfield ..	40,000	14.12	3	0	0	0	1
Jacksonville.	16,000	16.00	0	0	0	0	3
Freeport ....	13,258	19.00	2	0	0	0	0

Chicago:

During February "grip" was practically epidemic. The smallpox is proving undoubtedly more severe than in recent years. Fifteen have died of smallpox during the months of January and February. A bacteriologist has been provided by the Department to devote his time exclusively to the examination of scarlet fever cultures. Cultures are to be taken from the throat in a manner similar to those taken for diphtheria. Whooping cough caused 35 deaths during February, ranking next to typhoid and diphtheria among the contagious and infectious diseases.

## Correspondence.

### CORRECTIONS.

Chicago, March 7, 1903.

Dr. Geo. N. Kreider, Springfield, Ill.

Dear Doctor: I greatly regret that I did not have an opportunity to revise my remarks in the last issue of the Illinois State

Journal. I have been misquoted several times in the discussion of Dr. Marcy's paper, but the most serious misstatement is on page 612, where I am credited with saying that an "infected thrombus was found in the cul de sac."

This is not true and is a serious reflection on the service of the Lying-In Hospital. The case was one of pyosalpinx. The abscess was in the cul de sac, but there was absolutely no evidence of external infection. The case was conducted from start to finish with every detail of the perfect technique which characterizes all the work at the Lying-In Hospital. The sac was probably ruptured by the uterine contractions.

I trust you will publish this correction and oblige.

Yours truly,  
Charles B. Reed.

Sycamore, Ill., March 10, 1903.

Editor Ill. Medical Journal:

With all due respect to my much esteemed friend Dr. Reed of Chicago, I must dissent from some remarks he makes concerning my "severely criticising" him or his valuable paper on the use of the curette.

Every tinker, tailor, soldier, or sailor, should not use a curette. But I still think that a dull curette, in proper hands is a very valuable and useful instrument; and the case I referred to, and mentioned to the doctor was one, where one of these posthole auger machines, was screwed right up through the fundus.

Yours truly,  
C. B. Brown.

## State Items.

### STATE ITEMS.

#### Legislative Items.

Senator Clark's bill providing for the examination, registration and licensing of Trained Nurses, has passed the Senate.

The Harvey Medical College of Chicago, has proposed affiliation with the University of Illinois. At the annual meeting of the Trustees of the University, a committee of three was appointed to visit Harvey Medical college

and make a report. The committee consists of Samuel A. Bullard of Springfield, Alexander McLean of McComb and August F. Nightingale of Chicago.

Warren Reed of Chicago and St. Louis was found guilty at Cedar Rapids, Ia. of breach of promise in a case brought by Miss Jennie Dunn, who was awarded \$5,000 damages. The doctor wrote her seventeen passionate love letters and every one of them was read in court. They were filled with love, poetry, kisses, and hugs, and much scripture. The doctor claimed to be able to perform miracles by the laying on of hands. He told of miracles effected in St. Louis, where he had made the blind see and the lame walk. He asked Miss Dunn to advise a friend, a rich widow, to take treatment. Miss Dunn did so. The doctor came to Cedar Rapids and he and Mrs. Ella Snow, the widow, went to Chicago and were married.

"Dr." R. C. Flower, recently arrested in New York City, charged with grave crimes and misdemeanors, is an Illinois product and a part of his "record" was made in his native state. For this reason we give the following history of the rise and fall of the notorious swindler.

1849, December 11—Born in Albion, Edwards County, Ill., son of Rev. Alfred Flower.

1849 to 1860—Educated in private schools.

1860 to 1868—Prepared for university course and was graduated from Northwestern University of Indianapolis.

1872—Admitted to the bar and practiced law in Louisville, Ky., after studying law, medicine and theology at the same time.

1874—Abandoned the law and took up the ministry, preaching in Illinois, Indiana and Ohio.

1875—Studied to become a "healer" with Andrew Strong of Troy, N. Y.

1882—Practiced medicine at Brookline and Washington streets and 1762 Washington st., Boston.

1885—Traveled through the United States, lecturing on medicine and selling one-year treatments.

1888—Established Flower-Thompson Medical Company in East Thirty-fourth street, New York, selling bonds at \$1,000 each. Captain W. H. Thompson, whom Flower interested in the scheme, was arrested.

1889—Flower arrested for practicing medicine in New York without a license.

1890—Organized company at 559 Columbus avenue, Boston, capital \$1,000,000, par value of shares \$25, dividends \$1 per month, to build "the Flower Hotel." Organized another company to build a "sanatorium." Floated silver, coal, copper and land companies.

1891—Hotel Flower proved a failure. Dr. Flower sailed for Europe.

1892—Bought Silver Cliff mine at Sheriff's sale for a small sum and floated Security Mining Company, with capital of \$10,000,000 at \$10 a share.

1893—Medical Company organized by Dr. Flower resumed business at 559 Columbus av. Boston.

1894—Arrested in Terre Haute, Ind., but



escaped; chased through several states and located at his home in Boston; fled before extradition papers arrived.

1894, Dec. 1.—Arrested in Galveston, Tex., on charge of swindling H. C. Foster, a Wisconsin lumberman, out of \$49,000; held in \$10,000 bail; rearrested upon returning to jail to get his personal effects on charge of D. R. Chapman of Peoria, who claimed Flower had swindled him out of \$350,000 in stocks and bonds of Illinois Coal & Coke Company; released on \$10,000 bail and arrested a third time for embezzlement; arrested with Arthur Mosher, his private secretary, in Chicago, and taken to Peoria, Ill.; indicted by grand jury and held in jail in default of \$10,000 bail each.

Flower was at that time riding about the country in a private car with a secretary and servants treating such patients as could afford his prices. Each person was required to contract for a year's treatment and the money was required in advance. After the first treatment the doctor was never seen again, it is charged. From all over the country came complaints of his failure to keep his contracts.

While on one of these tours Dr. Flower was advertised to visit Terre Haute, Ind. The police in Chicago were notified of his route and Lieut. Andy Rohan, then a detective sergeant, was sent to Terre Haute to arrest him.

"Yes, I am Dr. Flower," the widely advertised man admitted. "I suppose that you know the man you want."

Rohan locked him up for safe keeping until he could get requisition papers. Then he discovered that according to the state law of Indiana a prisoner cannot be held more than twenty-four hours without a warrant or a requisition. Flower's attorney made the same discovery. In just twenty-four hours a writ of habeas corpus was asked and granted and Flower departed for California. Afterwards he was caught and brought to Chicago under arrest. A heavy bond was required and furnished.

"I do not remember what the result of the case was," said Lieut. Rohan. "The way I remember it was a case of some lawyers playing two ends against the middle and Flower getting away. Whether it was that or he jumped his bail I am not sure. But he got off."

"Flower was then over 40 years old and a smooth sort of a citizen. There were hundreds of complaints made against him, but he managed to get out of all of them. He had a big sanitarium in Boston at that time, according to his story, and there was some trouble there. But his private car and his big posters and secretary and servants made a big hit, and the people could not sign contracts quick enough. I had not heard of him for some years. I never saw him until I arrested him in Indiana."

1897—Filed petition in bankruptcy.

1898—Fitted up luxurious offices at 10 Wall st. and floated the Arizona Eastern & Montana Smelting Company, realizing large sums from sale of stock.

1899—Moved offices to 23 Wall st. and opened offices in Boston, Washington and other cities. Firm name changed to Flower, Ashton & Co.

1900—Induced Mrs. Francis Freeland Hagaman to invest heavily in his Arizona Eastern Company and traveled with a party to Mexico.

1901—Arizona Eastern & Montana Smelting Company in a bad way. Dr. Flower went away, but subsequently appeared floating schemes in Mexico.

The condition of the almshouses and jails in many counties in southern Illinois is declared to be unsanitary and dangerous to health by the state board of charities in its seventeenth annual report.

Criticism is aroused by the alleged neglect and lack of care, old and unsanitary buildings, bad plumbing or none at all, lack of bathing facilities, impure and insufficient supplies of water, and inadequate fire protection.

With the exception of the institutions found wanting in essential comforts the commissioners believe the general conditions are improving in other parts of the state.

### Local Societies.

The Champaign County Medical Society at the February meeting listened to a paper by F. W. Powers of Champaign, on the X-Ray in the Practice of Medicine.

E. Fletcher Ingalls of Chicago, by invitation, gave an address on State Organization. The Society after a full discussion, of the subject, voted to become a branch of the State Society.

In the evening, in the parlors of Beardsley Hotel, the annual banquet of the Society was given. About thirty-five members were present.

Jas. S. Mason,  
Official Reporter.

The Vermilion County Medical Society met Monday evening the 9th, in the City Hall at 8:20 o'clock; called to order by the President H. F. Becker.

Minutes of the February meeting read and adopted.

The board of censors reported favorably on the name of Jolomen Jones followed by his election to membership.

The paper of the evening was on auto-intoxication by J. A. Chaffee which brought out a general and valuable discussion closed by the essayist.

T. E. Walton reported a case of Ophthalmia Neonatorum and also a case of Hemorrhagic Smallpox.

Adjourned.

E. E. Clark,  
Official Reporter.

The Will County Medical Society held a clinical meeting at St. Joseph's hospital on Tuesday evening, March 10th.

Meeting called to order at 8:30 by President Curtiss. Minutes of previous meeting read and approved. Secretary then read communication from State Secretary Weis, calling at-

tention to the new plan for combining the local, state and national organizations; action upon which will take place in April.

The following cases were presented: **Exophthalmic Goitre**, Dr. Benson; **Heart Lesions**, Dr. Benson; **Acquired Syphilis**, H. A. Patterson; **Skin Grafting**, W. B. Stewart.

Each case was carefully discussed by members, and as our first clinical meeting was such a decided success it was proposed that we have a series of such meeting and see if we cannot arouse more enthusiasm in our Society.

After the completion of the program the members were treated to a delightful luncheon and cigars.

Following is the result of election of officers for ensuing year.

President, W. H. Curtiss, of Wilmington; Vice-President, H. W. Woodruff, Joliet; Secretary and Treasurer, H. A. Patterson, Joliet; Board of Censors, Wm. Dougall, W. B. Stewart, W. R. Richards.

Harry A. Patterson,  
Official Reporter.

The Peoria City Medical Society met Tuesday evening, March 3, 1903, at the National Hotel, and was called to order by President, R. A. Hanna. Those present were Hanna, E. H. Bradley, Marcy, Roberts, Whitten, J. V. Studer, Roskoten, Mansfield, Green, Hasson, J. S. Miller, S. M. Miller, F. B. Lucas, Stephenson, E. L. Davis, C. E. Davis, Mc Ilvaine, W. T. Sloan Brobst, Limner, Hensley, Plummer, Wahn, Eckard and Collins.

The Censors reported favorably on the application of M. V. Gunn of El Paso, Ill., and he was unanimously elected to membership.

E. H. Bradley made a motion that a committee of three be appointed to arrange for a banquet on or about the 55th anniversary of the organization of the Society. The Society was organized April 19th, 1848. The motion carried and the President appointed Hensley, Whitten and Brobst.

M. L. Harris, President of the Illinois State Medical Society, read a paper entitled: **Some Surgical Infections due to the Colon Bacillus**, which was discussed by Roberts, J. V. Studer, Roskoten and Marcy.

Adjourned. C. U. Collins,  
Official Reporter.

The Peoria City Medical Society met Tuesday evening, March 17, 1903, at the National Hotel, and was called to order by President, R. A. Hanna.

The members present were Brobst, Horwitz, E. L. Davis, Hanna, Hensley, Marcy, Roskoten, Jeannette Wallace, Sutton, Kane, Mc Fadden and Collins.

J. W. Hensley reported for the Committee on Banquet that Mr. Montrose of the National Hotel would furnish a banquet for \$1.50 a plate to be served in the Ordinary. The Committee asked for definite instructions from the Society.

M. S. Marcy made a motion that the banquet be held April 21st, or as near that date as could be arranged. Carried.

A motion was made by C. H. Brobst that \$1.50 be the price paid per plate. Carried. He urged that those attending should arrive promptly at 7:30 P. M.

M. S. Marcy moved that the Committee be given power to make all arrangements that they saw fit for the banquet. Carried.

O. J. Roskoten reported that a member, R. W. Baker, was sick. J. W. Hensley made a motion that the Secretary be instructed to write a letter to Dr. Baker expressing the sympathy of the members for his illness. C. H. Brobst offered an amendment instructing O. J. Roskoten to send some flowers to Dr. Baker. Both motion and amendment carried.

A. J. Kanne made a motion that the Secretary be instructed to write to the Chairman of the House Judiciary Committee, and the Chairman of the Senate Committee on License and Miscellany, and to the Members of the Legislature from this District, urging the passage of House Bill No. 626 and Senate Bill No. 370. Carried.

A. J. Kanne called attention to the time of holding the County Meeting in April. M. S. Marcy moved that the County Meeting be passed over, because not one physician from the County outside of Peoria was present at the County Meeting held last April, which was held in the afternoon to accommodate physicians outside of the City. Carried.

E. L. Davis read a timely paper on **Influenza** which was discussed by Hensley, Marcy, Roskoten, and Kanne.

Adjourned. C. U. Collins,  
Official Reporter.

The East St. Louis Medical Society convened at the office of President Rendleman, at 8:30 P. M., January 5, 1903.

Members present were: C. W. Lillie, Grimes, McLean, Stanton, Whitmer, Cox, Campbell, Hagerty, Adams, Bottom, Hanson, Hertel, Housh, W. E. Wiatt and W. S. Wiatt.

The Board of Censors reported upon J. D. Nifong, Joseph G. Battell and J. C. Klutho, and recommended them for membership. They were elected.

C. W. Gowans, 600 Elizabeth avenue, city, was proposed for membership by W. H. McLean. Referred to Board of Censors.

Whitmer read a paper on **Treatment of Scarlet Fever**.

Motion by Wiatt, Sr., seconded by Hanson, that the Society elect officers. Carried.

Motion made by Campbell, seconded by Wiatt, Sr., that each member vote for whom he pleases on the first ballot and that all except the two having the greatest number be dropped. Carried.

According to above, Hanson and Whitmer were again balloted upon. This time there were 17 votes cast of which Whitmer received 9, Hanson 6 and Rendleman 2. Whitmer receiving the majority was declared duly elected.

Campbell nominated Lillie for secretary. Lillie elected by acclamation.

Dr. Fairbrother nominated Dr. McLean for treasurer, and he was elected.

President Whitmer delivered a short address. Motion by Nifong, seconded by Fairbrother,



that we extend a vote of thanks to Dr. Rendleman for his kindness in permitting us to meet in his room in the past and for his kind invitation to do so in the future. Carried.

Dr. McLean, treasurer, made report as follows:

Receipts.	
Dues .....	\$23.00
By Subscription.....	12.00
Expenditures.	
Floral offering for Dr Stack.....	\$12.00
Floral offering for Dr. Corr.....	12.00
	<hr/>
	\$24.00
Deficit of last year overdrafts.....	3.71
Balance .....	7.29
	<hr/>
	\$35.00

Hanson moved, Wiatt, Sr., seconded, that a committee be appointed to amend the by-laws. Carried. Dr. Adams and Dr. Bottom were appointed.

C. W. Lillie,  
Official Reporter.

**The St. Clair County Medical Society** met in regular session at Priester's Park at 3 o'clock P. M. on Thursday March 5th, 1903.

H. C. Fairbrother, president, in the chair.

C. W. Lillie, secretary.

Starkel, Adams, Wiggins, Irwin, Hansing, Hilgard, and Twitchell, members, and Drs. David Zepin, E. M. Sasvil and Thomas Hagarty, all of East St. Louis, guests.

Treasurer Hansing presented a report showing those delinquent.

Dr. Lillie, Starkel, second, offered the following:

Resolved, That any member in arrears for annual dues may, at any time before the next regular meeting in June, 1903, pay one dollar to the treasurer and obtain a receipt in full of all delinquencies.

Resolved, That any member failing to pay, after notice has been given, shall, at its June meeting, be dropped from the roll of membership in this society.

The resolution was unanimously adopted, and the treasurer was instructed to notify all delinquents.

The committee to nominate officers reported as follows:

For president, C. W. Lillie; for vice-president, C. H. Starkel; for corresponding secretary, Geo. Hilgard; for recording secretary, B. Portuondo.

The report was accepted and the several officers were elected by acclamation.

Dr. Wiggins presented a liver which had been treated with a formaldehyde embalming fluid and rendered so hard while in its natural position that when removed from the body it still retained its normal shape. The doctor gave an excellent description of the liver, demonstrating its various anatomical features.

Adams reported a case of nasal stenosis caused by a large fibroid tumor with a small pedicle attached to fossa of Rosenmuller, and smaller polypus attached to left turbinate. Removal of both entirely relieved the trouble for which relief was sought.

Adams also reported two cases of rhinolith and presented specimens, one showing a small seed as a nucleus, and the other having as its nucleus a small wad of paper. The first was a female patient forty-one years of age, and as the nasal troubles dated from early youth the conclusion was that the rhinolith must have been more than twenty-five years in reaching its size at time of removal.

In compliance with a resolution the following committee was appointed to revise the by-laws of the society to correspond with the new laws of the state society, with instructions to report at the next meeting; Starkel, Lillie and Hansing.

The secretary read a letter from J. L. Wiggins, presenting to the society a copy of the first ballot of the American Medical Association under the reorganization.

Motion—Lillie, Starkel—that a vote of thanks be tendered Dr. Wiggins. Carried unanimously.

E. M. Sasvil, Thomas Hagarty and David Zepin were proposed, and being recommended, a motion was made, the rules suspended and they were elected by acclamation.

The president called attention to the fact that this was the first regular meeting since the death of Julius Kohl, and asked members for expression of feelings regarding our late brother. Fairbrother responded paying a glowing tribute to the memory of our lamented member.

Dr. Fairbrother was followed by Dr. Hansing, spoke feelingly of the generous character of Dr. Kohl, who did not hesitate to extend financial aid to the needy.

Dr. Wiggins thought the keenest enjoyment would be experienced by Dr. Kohl could he but know that he was so remembered by the society he so much loved.

Society adjourned.

B. H. Portuondo,  
Official Reporter.

**The Sangamon County Medical Society** met for regular session in the supervisor's room at the court house, March 9, 1903, at 8:30 o'clock with B. B. Griffith, vice-president in the chair and 21 members present. The minutes of the February meeting were read and approved. The applications for membership of J. R. Burkhart, Hada M. Burkhart, and C. R. Spicer of this city were read and referred to the committee composed of J. N. Dixon, L. C. Taylor and S. E. Munson.

Bills of Phillips Bros. \$1.50, secretary \$2.00, Springfield News, 80 cents and State Register 90 cents were read, after being o. k'd by the board of directors they were allowed and ordered paid.

The board of directors and secretary were appointed as a committee to procure new application blanks.

The following amendment to our by-laws in conformation to that of the State Society was read and adopted:

Physicians residing outside of Sangamon County who are members of the County Medical Society of the county in which they reside or where there is no county society may be



made non-resident members of this Society so long as they retain their membership in their own county society in case there is such society. They shall pay when coming from counties in which there is a county society, an annual due of two dollars, otherwise they shall pay the usual due and shall be entitled to receive programs of the meetings but shall not be entitled to vote or hold office nor shall they be counted as members in determining the number of delegates to the Illinois State Medical Society, excepting when they come from counties in which there is no county society, nor shall this society be assessed by the State Society for them as members.

There shall be a committee on legislation and the enforcement of the medical practice act.

The annual dues of this Society shall be three dollars payable in advance at the April meeting.

This Society upon approval of the board of directors shall pay through the secretary-treasurer to the Illinois State Medical Society, upon the receipt of a properly executed assessment, the sum of two dollars per annum for each member who has paid his dues and all members for whom such assessment shall be paid shall thereby become members of and be entitled to all the rights and privileges of membership in the Illinois State Medical Society and receive the Illinois Medical Journal, provided that no part of this article shall be in force until the Illinois State Medical Society shall adopt proper rules and regulations making the same operative and effective on its part.

J. W. Kelly read a paper entitled **the condition of the vascular system in nephritis**, which he stated might as well have been entitled, **the condition of the kidneys in vascular disease**, as many cases of kidney disease, particularly contracted kidney, is secondary to diseases of the arterial system. In all forms of nephritis there are some pathological changes in the cardio-vascular system, the acute form is all that will be considered in this paper. In this form as in that of scarlet fever and other infectious diseases we find degeneration and desquamation of the epithelium in the glomeruli and usually a decrease in the vessel walls which swell and acquire a homogeneous hyaline appearance. In chronic interstitial nephritis, aside from the kidneys themselves, more attention is directed to the heart, than any other organ, not including cases in which uremia confronts us and we have the brain to deal with.

Hypertrophy of the left ventricle (and sometimes the right) is a secondary factor when disease of the heart accompanies interstitial nephritis. The heart disease may be the primary disease and secondarily lead to disease of the kidney, as a result of disturbed circulation, heart and kidney disease may develop independently of each other, as a result of injurious influences that affect both organs at the same time, as arterio-sclerosis leads to cardiac hypertrophy or myocarditis and granular kidney as a result of implication of the renal vessels. Toxic and constitutional influences, alcohol, syphilis or improper living,

may cause disease of the heart and kidneys at the same time.

Renal disease may be the primary lesion and is itself a cause of a change in the heart, especially the secondary hypertrophy of the left ventricle. The retention of urea and other urinary constituents in the blood cause the increase of arterial tension. The disturbances are widely disseminated, involving the heart, large and small arteries, the capillaries and sometimes the veins, the lesions of the heart involve the muscle and find their expression in hypertrophy and many times dilatation. Late in the disease we may have fatty degeneration, valvular lesions are very uncommon, hypertrophy of the left ventricle predominating, if patient lives long enough the right ventricle will become hypertrophied. Early in the disease the lumen of the arteries is diminished from contraction of the muscular coat, later on account of the increased arterial pressure, the re-action of the heart and degeneration of the arterial walls, the result of defective nutrition the lumen becomes increased. The cause of these cardio-vascular changes has not been thoroughly worked out. The cardiac hypertrophy is often the first intimation of nephritis. Dyspnoea, increased flow of urine, nose bleed, headache and dizziness in the aged should arouse suspicions of early Bright's disease. In relation to the circulation, the brain indicates irregularities, hence it suffers early from deterioration of the blood vessels and gives the first symptoms of serious change in blood pressure. In arterio-sclerosis we have contracted kidney, and it must be kept in mind that the arteries in the brain and kidneys may be in a worse condition than will be found at the wrist, temples and neck. The paper being lengthy can only give a brief synopsis here.

In the discussion which followed, L. C. Taylor said that the urine was often a secondary consideration as to the prognosis in chronic interstitial nephritis and should not always be looked upon as local but systemic disease. When you meet with a resistant pulse, be sure to make a careful examination of the urine microscopic and chemic. We often find non-albuminous urine with casts in nephritis. With hypertrophy of the left ventricle you will find a hard pulse.

J. N. Dixon complimented the writer for the paper and said he was not prepared to discuss it intelligently.

A. E. Prince stated that after nephritic retinitis developed, the patient as a rule would not live more than eighteen months.

H. B. Buck considered the vascular system a very important part to be considered by examining physicians for life insurance.

E. P. Bartlett considers the nervous system responsible for the changes of the vascular system in nephritis.

G. N. Kreider spoke of the necessity of a careful examination of the vascular system from the surgeon's standpoint.

A. E. Prince reported a case of an old man who had retention of urine, caused from enlarged prostate. After failure to introduce the catheter, through the prostrate it was partially

withdrawn and a few drops of suprenalin solution was injected through catheter, in a few minutes, the blood being driven from the tissues the catheter passed into the bladder with ease.

Society adjourned.

Percy Louis Taylor,  
Official Reporter.

The Adams County Medical Society held its regular monthly meeting in Quincy at the Conservatory of Music, Monday, March 9, 1903, at 1:30 P. M. President Gilliland, presiding.

Members present J. G. Ash, L. B. Ashton, A. H. Byers, C. D. Center, R. J. Christie, Jr., W. E. Gilliland, H. M. Harrison, T. B. Knox, Virgil McDavitt, E. B. Montgomery, H. J. Nichols, L. H. A. Nickerson, C. W. Pfeiffer, Jos. Robbins, G. E. Rosenthal, Wm. Sigsbee, Sarah Vasen, J. G. Williams, W. W. Williams, S. J. Wilson, Ernest Zimmermann and John A. Koch.

An invitation was received from the Quincy Medical & Library Ass'n. to attend its regular meeting March 12, 1903, to hear an address by Wm. E. Gilliland of Coatsburg, the subject entitled *Then and Now*.

A. J. Enlow of Liberty and J. H. Pitman of Camp Point were elected to membership.

E. B. Montgomery read a paper entitled: *On the Question as to Time for Operation in Appendicitis: Report of Cases in Support of Position Taken*.

There is no chapter in the history of American Medicine in which we have so much reason to feel a just pride, as that which relates to the treatment of appendicitis and the careful work done by American surgeons in showing its precise pathology. They have demonstrated beyond question that it is essentially a surgical disease and must be dealt with by surgical methods. Beginning with Thos. G. Morton, Wm. A. Byrd, and others as pioneers. We have now accumulated such abundant clinical evidence by the work of Deaver, Morris, Murphy, Mynter, Ochsner and others, that English and Continental physicians and surgeons have adopted the American view, and the subject may now be said to have passed from the domain of legitimate controversy to that of settled fact. This being the case it is a matter of sincere regret that there should still be wide divergence of opinion on so practical a matter as the time for surgical interference, between men of the highest skill and sagacity, and teachers of far-reaching influence in the profession. It is because I have some views on the subject, the result of my own experience, that I make bold to contribute my mite toward the settlement of this vexed question.

Deaver, Morris, Weir, Murphy and others believe that an operation should be done as soon as possible after the diagnosis has been made and suitable arrangements for its performance perfected. Others, of whom Schraday is probably the most influential, while believing in immediate operation if the case is seen within the first 24 or 36 hours after the onset of the inflammation, advocate waiting if one is called later, until the abscess, if one is

present, is sufficiently "walled off" from the general peritoneal cavity to render operating safer. As Ochsner expressed it in a discussion of the subject before the Surgical section of the American Medical Association last year at Saratoga: "All cases coming to the surgeon within the first 36 hours, and all cases in the free interval, should be operated on immediately. Later than 36 hours, in most cases, it is too late for an early operation, and too early for a late operation. In these cases coming too late for early operation, he follows his method of withholding food and drink by the mouth absolutely, washing out the stomach and large intestine, and if necessary using rectal feeding for several days or until acute symptoms have subsided." This position has been vigorously combated by Deaver both in the discussion at the Saratoga meeting, and in an article in the American Journal of Obstetrics for November 1902, entitled "starvation treatment irrational in appendicitis." In this contribution he cites a number of cases in which this method had been used at the German Hospital in Philadelphia, and the results had proven disastrous. He strongly advises operation as soon as the diagnosis is made, whether this be in 12, 24, 36, 48, or 72 hours from the onset of the inflammation.

Personally, my experience has been very favorable to the method of withholding all food and drink, not only in local or general peritonitis, but in all inflammations of the gastro-intestinal tract, and in cholera morbus and cholera infantum, while it is absolutely essential to any successful treatment of gastric or duodenal ulcer. Many an infant has perished from persistence in feeding milk or other aliment, when the simple withholding of it would have sufficed for the perfect recovery of the child. But after admitting the usefulness of this therapeutic measure, my experience with it as well as my reason would lead me to avoid reliance on it as a substitute for the earliest possible operation in appendicitis, and three cases of tolerably recent occurrence in my practice will serve to illustrate.

Case 1. M. U. female, aged 11 years about 4 months previous to present attack had a mild catarrhal appendicitis yielding readily to abstinence from food and drink and flushing colon, gastric lavage and rest. In the beginning of this attack she was seen by Ernst Zimmermann in my absence, on the first day. All food and drink were withheld and hot fomentations used locally. The temperature kept under 101, pulse 90 and there was comparative freedom from pain. About midnight of the 4th day there was great exacerbation of pain in the right iliac fossa, and on visiting the patient I found her with a temperature of 102 and a decided mass in the appendiceal region. I advised immediate operation and arranged for it at the patients home by early daylight, Ernst Zimmermann, Rook and Williams assisting me. The McBurney incision was used, and a small intraperitoneal abscess containing about 3 drams of pus of highly faecal odor was found. After surrounding it with gauze to protect the general peritoneum, it was cautiously opened and the pus absorbed



by bits of gauze, then the abscess cavity was gently swabbed out with bits of gauze saturated in a 5 per cent solution of carbolic acid.

The cavity was loosely packed with a strip of iodoform gauze, and sterile gauze dressings in abundance used for the external wound, no attempt being made to suture it. As the appendix formed part of the wall of the abscess cavity, no attempt was made to remove it, lest the general peritoneal surface might become infected. The external dressings were changed on the day following the operation, but gauze was not removed from the abscess cavity for 72 hours, at which time it was gently swabbed with a 5 per cent. solution of carbolic acid before renewing the packing which was used in smaller quantity. This was changed every other day until healing was complete, the patients recovery being quite uneventful, and cicatrization entire after 28 days.

Case 2. E. Z. male aged 8 years had vomiting, fever, and abdominal pain and tenderness on the morning of November 2, 1902. This was treated by the parents with domestic remedies and continued unrelieved until the afternoon of the 4th when I was summoned. I found his temperature 103 and marked pain and tenderness at McBurney's point, advised immediate operation for which he was at once removed to Blessing Hospital and operation arranged for 8 o'clock in the evening. In this I was assisted by R. J. Christie, Jr., who gave the anaesthetic for a portion of the time until obliged to meet another engagement, when Miss Wheeler took charge of it, and by Ernst Zimmermann. McBurney's incision being used, a small intraperitoneal abscess was found back of the caecum, cautiously opened and the pus absorbed with gauze pledgets, after surrounding it with a protecting layer of gauze. The after treatment was the same as detailed in case 1, his recovery being uneventful. The patient was removed from the hospital in two weeks and cicatrization was complete on the 30th day after operation.

Case 3. F. B., male, aged 28 years had me called to see him November 26, 1902. I found him suffering with severe pain and tenderness in the appendiceal region of 24 hours duration, pulse and temperature normal, but free from nausea or vomiting. I ordered abstinence from all food or drink, and colonic flushing, and on account of the great severity of the pain morphia sulphas 1-6 gr. to be repeated in 3 hours if necessary. November 27th, I found his pain still more severe, frequent vomiting and temperature 102.5, and advised immediate operation, and removal to Blessing Hospital for that purpose. The same afternoon at 3:30 o'clock the operation was done, the usual preparations for abdominal operations having been made at the hospital. I was assisted by Drs. Ernst Zimmermann and L. L. Gill, the latter administering the anaesthetic. The McBurney gridiron incision was used, and the appendix found highly inflamed and adherent. In separating the adhesions a very small abscess at its base was ruptured, the contents soiling the general peritoneal cavity. The appendix having a large perforation communicating with the abscess was removed after liga-

tion with catgut close to the caecum, and the peritoneal cavity flushed copiously with hot deci-normal salt solution, some of which was allowed to remain. The peritoneum was sutured with a continued suture of catgut, and the abdominal wound closed with through and through sutures of silkworm gut.

On the 3d day following the operation there was evidence of intense infection shown by chill, high temperature, and pain and redness in the region of the abdominal wound. The silkworm gut sutures were removed the wound re-opened, and considerable very offensive pus of faecal odor removed. Fortunately the peritoneal cavity was closed to the infection but considerable sloughing of muscular and connective tissue about the wound followed. This while involving a somewhat tedious convalescence has not resulted in a hernia as I at one time feared it might. Cicatrization was complete after 84 days. In a future case should I be so unfortunate as to have an abscess rupture into the peritoneal cavity, while suturing the peritoneum, I should not tightly suture the abdominal wound, but leave a gauze drain in its lower angle. In cases 1 and 2 although the operations were done more than 48 hours after the onset of the attack the abscesses could as readily be dealt with as at a later period, and the time consumed in their complete healing was shorter than if the operation had been longer delayed. In these cases the starvation method had not prevented the formation of the abscesses, it could not have kept them from growing larger, nor if there had been a tendency to rupture of the abscess wall do I see how the absence of alimentation could have prevented it. This risk is much greater than any supposed advantage to be derived by waiting for more firm and extensive adhesions in the region of the appendix. I cannot but think therefore that Deaver and Murphy and those who think with them are right in saying that the best time to operate in appendicitis is just as soon as a certain diagnosis has been made, and an operation suitably arranged for.

The discussion that followed was quite lively and interesting but had no tendency to settle the "vexed question." The opinions differed as to the time to operate and as to treatment.

R. J. Christie, Jr., presented a specimen of a testicle removed on account of *tubercular orchitis*.

Our annual meeting occurs Monday, April 13, 1903, the next meeting.

John A. Koch, Official Reporter.

**The Quincy Medical and Library Association** convened at the public library the second Thursday evening of each month. One of the many benefits obtained from membership in this Society is the weekly circulation of the leading medical journals, to each member. The Society possesses a large number of volumes, one room in the public library being set apart as the doctors room. At the March meeting W. E. Gilliland read a paper entitled *Then and Now*.

Under this head I purpose presenting a few thoughts on the progress or advancement made



by our profession during the century just closed. I have brought with me a collection of books, written and published in the early part of that century. While they do not go back to the very beginning of the century, they do go back far enough to give us a pretty good idea of the status of the profession at that time. When we take into consideration the slow, plodding, stage coach gait of that period, we can readily perceive that these books faithfully represent the very highest advancement attained at the first of the century.

I discovered these books just on the eve of their destruction, in the effects of the late Dr. Joel Darrah, who practiced medicine in the vicinity of Coatsburg from about 1833 until 1866, and who was a graduate of the University of Pennsylvania, perhaps the most pretentious medical college on the American continent at that time.

Here I show you a work on the practice in two volumes called "Caldwells Cullen," published in 1822. Here I have "Thomas' Practice" published in 1825; and here I have "Eberle's Practice" in two volumes published in 1831. These three works on the practice of medicine, antedate those of Wood and Flint; and, being found in use among the graduates of the University of Pennsylvania, we are left to infer that they were the most complete and reliable works on the practice of medicine then extant.

Now I show you "Homers Anatomy," in two small volumes, certainly not a very pretentious looking work, published in 1826.

Now I present you with the most incisive work of the whole lot. I wish you to note carefully what effect the reading of the title will have on our friends, Christie, Jr., Johnston, Justice, Hatch, Hart, Knapheide and others. This work is Gibsons Surgery in two volumes and published 1825.

Here we have "Chapman's Therapeutics" in two volumes published in 1827. At the time I was reading medicine, between 1860 and 1870, this work was referred to by authors and teachers, more frequently perhaps than any of those I show you.

I now present you, in one small volume, published in 1831, "Cox's American Dispensatory," the particular primordial cell in which our great National Dispensatory of today was conceived. Could I place them here side by side you would have no difficulty in distinguishing the grandfather from the grandson.

I have one more work to present you—a work, as you see, in one small volume published in 1828 and is by no means void of interest. From time out of mind, when one of us arrives into this world, it has been found necessary to have at hand some handy help. Indeed, after having been, by a vis-a-tergo, literally thrust through the maternal straights, around the curve of Carns and into this cold world, many of us needed help, at the time this book was written, this delicate and responsible duty was assigned to such female help as was attainable, not the girls and inexperienced old maids, but the matrons, mothers of children, the wives of other men. Hence this accomplishment (it did not deserve the name of

Science then) received the appellation of Midwifery—not Accouchement or Obstetrics—but midwifery. The volume I show you is "Deweese Midwifery."

These books were all published in the decade just prior to my advent into the world. A sight of them on the shelf, always awakens in me, a train of thoughts, which were always pointed backward and which invariably conducted me upon the theme of the improvements we are making all along the lines of civilization and refinement—of science and industry, and invariably wound up on the progress, advancement and improvement that made, in ours, the most delicate, the most responsible, the noblest of all the professions.

A sight of these books on the shelf beside some of our magnificent modern works, led me to draw a comparison, and it suggested the idea that in them we have a standard for the measurement of the improvement we have made. I further believe it is the duty of this generation to transmit these works to future generations, that they may also be benefited thereby. As these relics enable us to look backward and observe the different rounds in the ladder by which we have attained our present height, we certainly should be sufficiently interested to transmit them to our children for a similar purpose, when they have attained even greater heights than we have. The preservation of such books and relics, ought to be, and I believe is, one of the chief objects, to be attained in the establishment of public libraries. For these reasons I have brought these volumes here and desire to deposit them in this library for all time to come; for the purpose above indicated.

Having disposed of the books I presume we might now be permitted to indulge in a few thoughts on the advancement or improvement which they so graphically display.

Before commencing that part of our subject, let me express the hope that what I have said to you will not excite in you a sentiment or feeling of disgust or contempt, for those noble old Grandsires and pioneers in our profession, who laid, and were then laying the foundation for the magnificent superstructure—the temple—which we are permitted to enjoy. Then let the remarks which follow be taken, rather as an excuse or an apology for what may appear to us, as their shortcomings and imperfections.

The writers of these books devoted much time and attention to nosology or the classification of diseases. It seems that it would have been a rank violation of the rules of propriety to have treated a disease without a name; and, it was likewise necessary that it should be assigned to a class; because, all diseases belonging to a particular class were treated in a similar manner. For instance, if a disease belonged to the class Phlegmasia, it was treated with antiphlogistics. The naming and classifying of diseases by these authors would make a very interesting study, but it is one that would take up too much time for our present purpose; therefore all that part of the subject pertaining to the naming and classifying diseases will lie between where we stand and the first place where our little stone will strike.

There we shall touch lightly on the subject of diagnosis and their means of making diagnosis.

Take for instance the disease—Pneumonia—a disease in which we seldom have any trouble in making the diagnosis. In Caldwell's Cullen, the very first paragraph on that disease reads thus "Under this title I mean to comprehend the whole of the inflammations, affecting either the viscera of the thorax or the membrane lining the interior of surface of that cavity" and then he continues and tell us "for neither do our Diagnostics serve to ascertain exactly the seat of the disease, nor does the difference in the seat of the disease exhibit any considerable variations in the state of the symptoms, or lead to any different method in the cure."

Eberle commences his chapter on Pneumonia thus "The term pneumonia is employed in a general sense to designate acute inflammations within the cavity of the thorax, whether seated on the Pleura, the mucous membranes of the Bronchi or the proper substance of the lungs." "The general characteristic symptoms of acute inflammation in the chest are, cough, difficult and painful respiration, fixed pain in the thorax and fever." "Considerable difference occurs, however, in the character of these symptoms, as well as in the other usual concomitant phenomena, according as the one or the others of the three structures just named, is the exclusive seat of the disease."

You will perceive that this is an improvement over the writings of Caldwell, and shows very nicely the advancement made between the years 1822 and 1831.

The definition Thomas gives us of Peri-pneumonia in 1825 is less definite and satisfactory then either of the others. He says: "Peri-pneumonia or inflammation of the lungs is denoted by a difficulty of breathing, obtuse pain in some part of the chest, cough, a frequent full pulse, vibrating under the finger, like the tense string of a musical instrument, high colored urine and other symptoms of inflammatory fever." "The disease is divided into true and false pneumonia." This distinction is made by all three of these authors. The term true or peri-pneumonia being used when the parenchyma of the lungs is involved. The chief cause of pneumonia, given by all three of these authors, is cold suddenly applied to the surface of the body and checking perspiration. But Caldwell says: "The pneumonic inflammation has been sometimes so much of an epidemic as to occasion a suspicion of its depending upon a specific contagion, but I have not met with any evidence in proof of this."

They had just three instruments or organs with which to ascertain the nature and location of any particular disease. They saw, they heard and they felt. With their eyes they saw the decubitus of the patient, the color and expression of his face, the character of his respirations and his relation to his surroundings. They observed as to whether he was prone upon his back, on his side or in a sitting posture, if, on his back, was he relaxed or rigid, if on his side, was he reclining at ease

or favoring some sore or painful part—if sitting up was it from choice or was he unable to lie down. They observed in his face as to whether it was flushed or pale, was it white as marble or tinged with yellow; was it gloomy and sad or bright and cheerful, was the forehead wrinkled and the mouth pinched, indicating intense agony or was it relaxed and expressionless indicating an advanced stage of grave disease, was the eye bright and clear or dull and lustreless, and finally was there an hypocritic expression indicating immediate dissolution.

With the eye they observed the tongue, what they learned by a sight of the tongue would fill a volume. They noted as to whether it was wide or narrow, was it flat and thin or round, thick and blunt or pointed, red or pale, clean or foul, naked or coated. If coated the character of the coat—was it short and close or long and shaggy, was it white or lead colored, brown or black, was it moist or dry, if dry was it cracked; and finally was it put out freely and with alacrity or did it come out tardily, feebly, and with trembling. Each and every one of these aspects of the tongue revealed to them some item of knowledge which they utilized in making up their diagnosis. In connection with the decubitus of the patient they observed the character of the respirations—were they normal, frequent, slow, was it deep and full, shallow and cramped, easy or laborious, and with the aid of their ears they observed if it were silent or sonorous, if sonorous was it simply natural snoring or was it the sturter of insidious disease, was it through the nostrils easily, or through the mouth with puffing and blowing.

Then they observed his relations to his surroundings. Had he observed the ordinary rules of propriety, undressing himself properly, or had he crawled in bed with his boots on, had he taken all his clothes off, and crawled in at the wrong end of the bed, or was everything in its proper place, indicating that nothing was the matter. Then with their ears—you will observe that they did not make the use of the sense of hearing that we do. They learned from the patient and his attendants, the history of the case, its inception, the manner of its beginning and the time it had existed and the course it had run. They—in some manner—learned if there was pain or soreness and of its location and character. They also learned something of the peculiarities of the patient; as well as of his occupation and of the exposures to which he had been subjected.

Then with their fingers they felt—everything that a well trained or educated finger could feel. In pneumonia, by the sense of feeling they ascertained the temperature of the body, was it cold, warm or hot—the condition of the skin—was it dry, moist or wet. Then they felt the pulse, aye with the finger they felt the pulse—what a world of knowledge was revealed to the educated finger by the pulse. They observed as to whether it was regular, or irregular, was it slow or rapid, was it soft or hard—was it full or small and thready, was it regular or intermittent—was its beats soft and receding or sharp and jerky, was it tense,



and did it vibrate under the finger like the tense strings of a musical instrument, or, finally was it one or a combination of several of these conditions.

Each and every one of these conditions of the pulse revealed to them some item of information which they utilized in forming a judgment and making up a diagnosis as to the nature of the disease in hand.

Having glanced at the means and facilities for ascertaining the inception, cause, location and nature of diseases that the authors of these volumes in those times had, we will now make another skip and take a glance at what they had not.

Our quotations were taken from their articles on pneumonia or inflammation of the lungs. Read those articles carefully all the way through and you will not get a hint or suspicion that they had the most remote knowledge whatever of the revelations of auscultation and percussion. In fact these, to us, familiar terms, are not used in either of these works, neither are the terms applied to the finding of these processes of physical examination. You will look in vain for the words flat, dull or resonant, or any of the sounds and murmurs elicited by auscultation. The woodman in selecting timbers for his purpose, had learned to determine with astonishing accuracy, as to whether a tree was sound and solid, hollow or rotten by the sound it returned on received a blow from the pole of his axe, long before the physician had dreamed of ascertaining the conditions within the human breast by percussion. The redman of the forest had learned to ascertain the approach of an anticipated enemy or friend, by placing his ear to the ground, long before the physician had learned to gain a knowledge of the normal or pathological conditions within the thorax by auscultation.

Is it surprising that Caldwell wrote in 1822 "For neither do our diagnostics serve to ascertain exactly the seat of the disease, nor does the difference in the seat of the disease exhibit any considerable variations in the State of the Symptoms." Could we with our unaided senses and with no other facilities than those, they had, have done any better? It is fair to presume not. With their bare fingers they ascertained the temperature, and formulated their conclusions as to the intensity of the fever. They could easily tell when the patient was cold, warm or hot; but they had no thermometer to measure and make those nice distinctions in the use and fall of temperature, which we esteem so highly as a means of diagnosis and prognosis; nor could they ascertain with any considerable degree of accuracy when the temperature itself was approaching the danger line.

They made observations of the blood, as to its color, its coagulability, and after standing sometime, as to whether its surface assumed a cupped shape—this latter being highly esteemed as a diagnostic sign of inflammation and an indication for bloodletting. But they had no microscope with which to make an estimate of the number of the corpuscles. In fact they knew nothing about the blood cor-

puscles, the micrococcus and the bacillus, and the hundred and one different germs or microorganisms which are now known to be the sole cause of certain of the diseases of the human family and of animals. It has now been pretty well demonstrated that even pneumonia—the disease to which your attention has been called this evening has its own specific coccus, the pneumonococcus.

Cullen prophesied better than he thought, when he penned the following—"The Pneumonic inflammation has been, sometimes so much of an epidemic as to occasion a suspicion of its depending on a specific contagion." Then when he had seen what a rent he had made in the canvas, he became alarmed and concluded the sentence in this wise—"But I have not met with any evidence in proof of this."

They had, as compared with ours, no chemistry, yes, they had chemistry of a kind—but it—like the microscope, had never been taught to minister to the wants of man. It had been trained toward making scientific discoveries and the conversion of other metals into gold. It had never been utilized in diagnosing diseases by analyzing the fluids and secretions of the body, nor had it been utilized in preparing the thousand and one elegant pharmacopoeal preparations that we are using every day. You and I would feel rather shaky about the diagnosis of a case of Bright's Disease that had been made without the microscope and without chemistry.

Besides those we have mentioned for diagnostic purposes, we might add, the ophthalmoscope, the auroscope, the laryngoscope, the cystoscope, the endoscope and vast numbers of speculums. I might go on with this enumeration at considerable length, but this is enough for our present purpose.

I have purposely omitted all reference to Surgery—surgical diagnosis—surgical appliances, because their consideration would make our present paper too voluminous. Suffice it to say that the advancement or improvement made in the practice and art of surgery, in the last century, has been—if possible—more strikingly apparent in that than in the practice of medicine.

Take this, at the time it was written, a voluminous work on Surgery by the greatest American Surgeon of his day, William Gibson, Professor of Surgery in the University of Pennsylvania, and behold how timidly they approached the vital organs of the human body. See how sacredly they regarded the cavities lined with serous membrane—the cranium, the pleura, the pericardium and the peritoneum. The invasion of any one of these cavities, unless it had been opened by accident, was regarded as a crime, for which there was no forgiveness and for which the boldest surgeon might have lost his head.

Now I want to revert again to what they had not; we have glanced at some of those instruments and appliances which we deem necessary for making accurate and reliable diagnosis; now let us glance for a moment, at what they lacked in the line of therapeutics.

At the time of the writing of these books our noble profession was not in the possession



of a knowledge of the value or medicinal effects of either quinine or morphine. Now let these serve to represent the condition of darkness in which the knowledge of scientific medicine and the practice thereof were then enshrouded. The salts of quinia were discovered, in the cinchonia bark about the year 1821, but had not been introduced into practice as a substitute for the bark until after the youngest of these books were written. The salts of morphia were known, perhaps earlier than those of quinia, but they seem to have been used rather to determine the value of any given lot of crude opium than as a therapeutic agent. It will be thus seen, that they recognized the active principle in the salts of morphia.

Doctors Cullen, Eperle and Thomas used the cinchonia bark in substance in decoction and in extract, the latter of which could be used in a pill form. They experienced no little difficulty in finding stomachs that would retain the nauseous doses.

They used opium in substance, decoction and tincture. In reading these books I have not seen quinia or morphia referred to as a remedy for disease, nor do their names occur in any of the numerous formula they have given us. In those days the doctor went to the drug store and bought crude opium, crude cinchonia bark and other equally crude drugs, and when he came to the bedside of his patient, he there brewed, decocted and concocted such remedies as the patient was required to take, and you can safely bet that they were not as pleasing to the eyes nor as tempting to the palate as some of our modern pharmacuticles.

Imagine if you please, our old grandsire, Dr. Benj. Rush, at the end of a five mile drive into the country, see him enter an old smoke begrimed log house, containing a single room, wide open fireplace at one end. He is lighted to the bedside of his patient with a smoky tallow candle; he is compelled to make his examination, no matter how delicate, in the presence of the whole household. This examination consists in asking a number of questions by which he acquires some knowledge of the case—its inception, duration, and subsequent course. Then he examines the tongue, and notes that it is covered with a brownish yellow coat. Then he feels the pulse—it counts 105, large and full, but a little inclined to be soft. Then he notes that the temperature is above the normal, and the patient is perspiring freely, and the word "Remittent Fever," involuntarily escapes his lips. The simple examination is concluded, he secures a small stew kettle and a tin cup, he puts a portion of water in each, he takes a fire shovel, and draws out on the earth some live embers and places the two vessels containing water, on them, he goes to his enormous old fashioned saddle bags and takes out a lump of crude opium and a package of powdered cinchonia bark; he puts a handful of the bark into the stew kettle and a small lump of opium into the tincup. Then he sits down and watches them for a half hour or until the decoctions are completed. He decants the one and strains the other through a linen rag. He takes a half teacupful of the decoction of cinchonia and offers it to the patient. Is not

that a sight for the gods; but it gives you a pretty good idea of the primitive methods of the practice of medicine in this great country of ours, a hundred years ago; indeed your humble servant can remember when it was but little better. He gathers up his great saddle bags and departs, and if he does not hear his patient vomiting before he gets out of earshot, he thinks he has scored a point.

You ask how these books become so yellow and water stained? That is an "old letter story." Our old friend Dr. Joel Darrah, when he arrived in this part of the great west, away back in the thirties, like all of his neighbors, lived in one of those primitive log cabins that you have heard so much about, which was covered with clapboards, fastened on with weight poles. This kind of roof was all sufficient against almost any kind of rain, but it was by no means proof against drifting snow. The ceiling in those old cabins consisted of some poles—substituted for joists, extending from side to side, and covered also with clapboards. The space between this clapboard ceiling and the clapboard roof was called the loft or overhead. This loft usually had a hatchway or opening, supplied with a ladder as a means of ascent and descent. This loft or attic was a depository or catch-all for all the odds and ends that could not be left out of doors. For the want of a better place these books found their home in just this kind of an attic for several winters, during which the snow blew in on them and when the warmer days arrived the snow melted and wet them more or less. This process several times repeated, like the process of coloring a meerschau pipe, brought them to the present state of antiquated appearance.

Sarah Vasen, Official Reporter.

The Chicago Surgical Society held a regular meeting Feb. 2, 1903, with the Vice-President, A. J. Ochsner, in the chair.

Jacob Frank presented the case of a girl, nine years of age, for diagnosis. A year ago she fell and limped for awhile. A year later the mother, having discovered that the child limped considerably, felt the child's knee and heard something snap. It was difficult for the child to climb stairs. On movements of the knee, a snap could be heard. He was inclined to believe that the case was one of chronic dislocation of the fibula. By extending and flexing the knee this snapping sound is felt.

A. E. Halstead said the case looked to him like one of dislocation of the semilunar cartilage, with relaxation of the crucial ligaments. He did not think the fibula had anything to do with the disability. The disability manifested by the patient in going upstairs is well-known as a symptom of movable body in the joint.

William Hessert concurred in the remarks of Dr. Halstead, that the condition was probably one of relaxation of the crucial ligaments, with a partial dislocation of the semilunar cartilage.

Arthur Dean Bevan said the most probable diagnosis is that of subluxation at the knee joint, due to great laxity of all of the ligaments of the knee. As to its being a dislocation of the semilunar cartilage, that diagnosis did not

appeal to him. He had never seen a case like it before. His reasons for believing it was not a displacement of the cartilage were, first, the child had never had any synovitis or great pain, as such patients usually have in connection with a displacement of the cartilage. Second, the displacements of cartilage he had seen have never given the picture of a sudden dislocation when the cartilage was held firmly in position. This diagnosis, however, is only a probable one.

**Daniel N. Eisendrath** asked why a diagnosis of dislocation of the right semilunar cartilage did not prevail. It would seem to him that such a diagnosis corresponded exactly with the clinical findings.

**Jacob Frank** reported a case of excision of the cecum in a child, nineteen months old. The child was playing on the floor, when suddenly it was seized with a severe pain, vomited, and passed blood, after which it became very ill. He made a diagnosis of intussusception. The mother took the child to the hospital; the abdomen was opened, and in examining the coils of intestine he did not find what he thought was a recent intussusception, but in making a further examination he came upon the appendix, which seemed as though it were binding down the cecum. He removed the appendix, and in following the cecum he found it was a hard mass. He therefore resected the entire cecum, making practically two operations. He used one of his absorbable bone couplers in making the intestinal anastomosis, and removed the stitches at the end of seven days. In ten days the child left the hospital. The child was now in perfect health.

**A. J. Ochsner** reported a case of **Stricture of the Esophagus treated by Gastrostomy and Gradual Dilatation.**

The patient, Mr. S., 34 years of age, admitted to the Augustana Hospital, Feb. 17, 1899, gave the following history: His parents were both old when they died. Two brothers and one sister died, but patient cannot state the exact cause of death. Aside from having had repeated attacks of malaria, the patient's health has been good since childhood. He lived in a malarial district during his youth. He has never swallowed lye, or any other escharotic. During the past fifteen years he has experienced some difficulty in swallowing. He first observed the necessity of drinking large quantities of water while eating, in order to wash down the food. The amount of fluid required has become greater and greater constantly. For a considerable time he has been in the habit of eating and drinking all he expected to consume at one meal, then he would drink several goblets of water, and with straining he would force the entire meal, which apparently had accumulated in the lower part of the esophagus, into the stomach. Then he would gulp up the superfluous water to the amount of about one pint.

Upon permitting the patient to drink one to two pints of fluid, he complains of a feeling of weight in the epigastrium. Percussion elicits an area of dullness in the epigastrium to the left of the median line, and upward toward the left nipple. Bismuth was suspended in the fluid swallowed, and skiagraphed. This showed

a club-shaped shadow in the area indicated by the dullness twelve centimeters wide at its widest point, which at the same time was the lowest portion. If patient drinks still more fluid, he becomes greatly distressed. This condition has become more and more distressing, the patient finding greater difficulty in forcing anything into the stomach. The symptoms indicate the presence of what has been called a spasmodic stricture of the lower end of the esophagus, but which is probably due to the peculiar arrangement of the muscles of the diaphragm at the point at which the esophagus passes through the latter structure in these cases, as has been demonstrated by a case operated upon by Ross of Toronto.

Every attempt of passing bougies of any size, even filiform bougie, through the stricture have failed, both with and without the use of cocaine. The patient's condition had become most pitiable, when the following plan of treatment was instituted: The patient was anesthetized and another attempt was made to introduce bougies of various sizes, but this again failed. An incision, twelve centimeters long, was then made through the outer edge of the left rectus abdominis muscle, opposite a point halfway between the umbilicus and the sternum. Bougies were again introduced into the esophagus through the mouth, but could not be passed into the stomach, neither could they be felt with the hand in the abdominal cavity. The anterior wall of the stomach was then brought up and sutured to the parietal peritoneum, and the transversalis fascia and the exposed surface of the stomach between the edges of the abdominal wound was tamponned with iodoform gauze. The essayist said that this part of the operation was not well planned; that some provision should have been made to prevent leakage after the stomach was opened, either by Witzel's method, or by some other equally efficient plan.

The stomach was opened two days later, and an unsuccessful attempt was made to bougie the esophagus from below. During the following week attempts were made daily to pass bougies through the stricture, but all of these attempts failed, until a fine flexible bougie found its way into the stomach, ten days after the operation. A number of attempts had also been made to pass a thread through the stricture by having the patient drink it with water, but these failed probably because of the peculiar form of the obstruction. Ordinarily a fine thread placed in a glass of water and threaded through a drinking tube can be carried through even a narrow stricture into the stomach if the patient drinks the thread with the water through the drinking tube. The end of this bougie was brought out through the opening in the anterior wall of the stomach, and a large-sized, braided silk suture was tied to its end. The bougie was then withdrawn and in this manner the silk cord was passed through the esophagus. A still heavier silk cord was now attached to this cord double, and was drawn through the esophagus, then one of the three ends of the cord was drawn through the loop and tied to the other three ends. In this manner a very convenient, con-



tinuous double-silk cord was placed permanently through the esophagus. The following day a small rubber tube was looped through this cord and drawn through the esophagus and left in place in the stricture for a few moments in order to dilate the latter. Then two rubber tubes were looped into the first one, and these were drawn through the constricted portion. Each day the size and number of these tubes were increased, until the mass of tubes measured three centimeters in diameter, when tightly pressed together. By this time the patient could swallow any kind of food normally, in any desired quantity. In the meantime, the gastric fistula had become very troublesome. One of the author's assistants, H. H. Hanstein, devised a very ingenious pneumatic rubber apparatus with which he closed the opening, but the patient insisted on having the fistula closed, and this was accomplished by an operation May 8, 1899, seven weeks after the original operation. The stomach was loosened and the wound closed by means of Lembert sutures. A small fistula persisted for some time, but healed under treatment with cauterization.

It is now four years since the operation, and it is still possible to pass an ordinary, olive-pointed bougie, fifteen millimeters in diameter, into the stomach. This has been done several times each month during the past year, on account of a tendency to recurrence. Swallowing has become more and more difficult, notwithstanding the fact that it is possible to pass these bougies. The author thinks it will become necessary sooner or later to perform another operation. He believes that the operation advised by Ross, which consists in a division of the constricting bands, will be indicated, and will probably give permanent relief.

Aside from the evident advantages this method presents in itself, it can be employed very satisfactorily in connection with the method described by Abbe as the bow-string method.

Jacob Frank asked the essayist what method he had used in closing the fistula?

Dr. Ochsner replied that the edges of the stomach were loosened from the abdominal wall, folded in and sutured by two rows of Lembert sutures; then the abdominal wall was sutured over this with silkworm gut sutures, and a gauze drain was inserted underneath the abdominal wall, but there was some leakage, which accounted for the appearance of the scar.

D. W. Graham asked if the essayist made out to a certainty that the stricture was below the diaphragm.

Dr. Ochsner said he was certain it was below the diaphragm, as he could feel the bundle of tubes strike the stricture regularly.

L. L. McArthur asked if a tumor of any kind could be felt with the finger in the abdominal wound before opening the stomach at the seat of the diaphragm, or whether the essayist could determine the nature of the stricture by such an examination?

Dr. Ochsner replied that no tumor could be felt at that point.

A. E. Halstead remarked that not long since he operated on a case of diverticulum. In this case a large bougie could be passed without any difficulty through the stricture, although a small one was impassible. The patient was unable to swallow food of any kind, either fluids or solids. After swallowing a mouthful or two of food, the diverticulum would fill again, and close the esophagus. This was a characteristic point in the diagnosis of a diverticulum.

A. I. Bouffleur remarked that while he had not had a large experience with the class of cases under consideration, his impression was that some dilatation of a stricture of the esophagus frequently occurred after a simple gastrostomy without the use of any bougie. With a stricture located as this one was, one ought to be able to dilate it with the finger, if the proper method were resorted to, and this method consisted in making an opening in the stomach early in the operation, to empty the stomach, and by having the opening very small, so that it would just pass over the finger, one could carry the hand well up in the abdominal cavity with the finger within the stomach. He remembered seeing Dr. McCosh dilate such a stricture a few years ago, at which time he introduced his whole hand into the stomach. There was serious objection to this, and by invagination the same effect could be secured without so much danger.

Daniel N. Eisendrath had seen a number of cases of stricture of the esophagus due to the swallowing of lye, in Vienna. VonEiselsberg performed a gastrostomy and putting in a stomach tube enlarged the caliber of the stricture constantly, leaving it in for a considerable period of time. He had obtained excellent results. The tube should be introduced and withdrawn at intervals of ten or fifteen minutes for a certain period of time.

Arthur Dean Bevan said, might it not be possible for one to have a stricture of the esophagus or esophageal opening in the stomach from a gastric ulcer, just as one would have obstruction of the pylorus, or obstruction from a carcinoma of the esophageal entrance of the stomach. Would it not be possible to imagine such a condition explaining the pathological condition? The exact cause of the obstruction in Dr. Ochsner's case was not clear to him.

Dr. Ochsner, in closing the discussion, said there was no doubt but what gastric ulcer could cause a stricture at the point mentioned. He had no doubt that there was a congenital element in his case.

W. H. Allport reported two cases of thoracic abscess pointing abdominally.

A. E. Halstead, Official Reporter.

The Chicago Surgical Society met March 2, 1903, with M. L. Harris, in the chair.

#### Removal of Birth-Marks.

L. L. McArthur described a method which he believes to be new for the eradication of vascular blemishes of the integument. As the red color of these marks is due to capillary dilatation, it is necessary to obliterate the capillaries. To do this, he conceived the idea that if, on a plane horizontal to the surface upon



which this pigmented area rested, a section was made of the integument in such a way that the entire thickness of the integument would not be destroyed, but that the knife should pass through each capillary loop as it came to the surface, he would then have integument still enough intact to prevent actual perforation of the same, with projection of the connective tissue beneath. After waiting for coagulation of the blood in these cut capillaries, a thin Thiersch graft was applied; all of these cut capillaries would then be obliterated, being plugged with blood-clot, which becoming organized, would simply destroy the pigmented appearance of such a mark.

Eighteen months ago a young woman presented herself with a very pronounced mark that extended over the forehead from the scalp to the eyebrow, including the eyebrow, the upper eyelid, and a portion of the malar prominence of the cheek. He adopted such a method as he described on a surface which had already received electrolysis and various other methods for the destruction of the vessels and color without avail, and succeeded in obtaining an excellent result. The patient was exhibited.

#### **A Case Two Years After Removal of Carcinoma of the Stomach.**

Dr. McArthur again presented a case exhibited to the Society several months ago. The patient was a man from whom he had removed a portion of the lesser curvature of the stomach and the anterior wall, with also a portion of the inferior surface of the left lobe of the liver, for carcinoma. He presented at that time the microscopic slides, which were pronounced carcinomatous, as the tissue could be seen involving the liver tissue without any capsular line of demarkation between the normal liver tissue and the new growth. At a previous meeting of the Society, the opinion was expressed that the man would soon succumb to a rapidly recurring carcinoma. He had not been convinced, as he recalled the cut surface of the liver from which the growth was excised, that he removed all of the growth. He knew that he had removed all of the stomach growth. The man was now doing work at St. Luke's Hospital as an employe there, and has increased in weight from 117 pounds at that time to 135 at present.

#### **Fracture of the Patella, with Suture of the Aponeurosis.**

Daniel N. Eisendrath exhibited a man who, while in an intoxicated condition, fell backwards and down a flight of steps, ten or twelve. The patient, in falling and trying to save himself, sustained a fracture by indirect violence, tearing the patella into two parts. There was a space large enough between the ends of the patella to admit his little finger (a distance of one-quarter or half an inch.) At the time he operated, it was his intention to show the students the method of operating upon fractures of the patella, i. e., to open the joint, and either wire the fragments or suture the patella with kangaroo tendon. As the drill would not work, he sutured the aponeurosis. He found the aponeurosis had been turned in at the edges of the fracture, and the fascia,

the periosteum and aponeurosis were turned in in a typical manner between the edges of the fracture. He pulled them out, brought the fractured ends closely together, and inserted four sutures of kangaroo tendon. The suture was passed through the aponeurosis on both sides of the patella, and two sutures were passed through the periosteum of patella itself. The accident to the patient occurred on the 12th of November, 1902. After the operation the patient was placed in a plaster-of-Paris cast. He operated the day following the injury. The incision was made transversely over the fracture. No opportunity was lost to resort to passive exercise and massage to recover function of the joint as well as possible six weeks after fracture. An X-ray picture taken six weeks after operation showed absolutely no separation of the fragments. The functional result is all one could desire.

D. S. Fairchild, of Clinton, Iowa, contributed a paper, by invitation, entitled **Some Observations on the Surgery of the Kidney.**

The questions which appealed to the author and to others of limited opportunities for observations were (1) in relation to trauma of the kidney not involving open wounds or wounds that have healed. (2) In relation to suppurative nephritis. (3) In relation to chronic degenerative disease of the kidneys.

An injury to the kidney, inflicted by a trauma to the back or abdomen, which does not produce a crushing lesion, is not often attended by symptoms of sufficient gravity to require immediate operation, and are serious mainly in the remote effects. The sequelae which bear an intermediate relation to the injury are suppuration, peritonitis, uremia, and persistent or intermittent hemorrhage. The more remote effects are aneurysm of the renal artery, suppuration of the kidney, and movable kidney.

Scerou has collected 6 cases of more or less complete anuria following injury, and only one recovered. In 5 of these cases the other kidney was normal. A considerable number of cases of injury to the kidney, with hematuria, have come under the observation of the essayist, unattended with open wounds, or with symptoms of such severity as to require an immediate or early operation. Cases were cited in point.

Aneurysm of the renal artery or its branches, as a consequence of subparietal injury, is a very rare condition, in that Morris, of London, has been able to collect but 19 cases. The difficulty of making an exact diagnosis of this condition, its great danger, together with the fact that it occasionally occurs as a late sequence of an injury, emphasizes the importance of an early operation in cases where a serious doubt exists as to the nature and extent of the damage which the kidney has sustained.

The presence of a tumor in the region of the kidney appearing after an injury is significant of some secondary involvement, either of the kidney itself or the perinephritic tissue. If the disease has its origin in the kidney, it will usually be recognized by the presence of pus in the urine, but in some cases the ureter

may become obstructed, and the pus disappear early, leaving an uncertain and somewhat obscure history for the surgeon to base a diagnosis on, or pus may never be discovered in the urine at all, on account of an early blocking of ureter. These conditions were illustrated by two cases, cited in the paper.

Diffuse suppurative nephritis of the more chronic interstitial forms is not infrequently overlooked. In one case which came under the writer's observation the condition was not discovered until the man was examined for life insurance.

The traumatic origin of floating kidney has been very thoroughly studied by M. L. Harris, and the paper published by this observer is well worthy of perusal. The speaker has examined a considerable number of alleged cases of loose kidney from injury, but in none was the organ abnormally movable. These observations may have been coincidences, for it is true that persons having an unsuspected floating kidney may be injured and the subsequent examination reveal the fact.

Arthur Dean Bevan reported the case of a man with an enormous hydronephrosis of the left side. A tumor was found occupying the entire left half of the abdominal cavity, with the descending colon distinctly in front of the tumor, as outlined by a distinct, sausage-shaped tympanitic mass in front of the tumor. The man was passing a small amount of urine, was sweating profusely, and the quantity of urine passed from the bladder never exceeded 800 c. c. in twenty-four hours in the few days while he was under observation. Under nitrous oxide gas, Dr. Bevan made a nephrotomy, opened a large hydronephrotic sac, and allowed a gallon of fluid to escape. The fluid was clear and did not contain any pus to the gross appearance. Most of the fluid escaped immediately after making the incision, as it was under considerable tension. After the operation the man passed about two ounces of urine in six hours, then there was dribbling of urine for twelve or eighteen hours afterwards, and another dribbling about twenty-four hours afterwards from the urethra. After that he did not pass a single drop of urine from the bladder. In the wet dressings from 50 to 60 ounces of fluid was found daily. The patient was watched for a number of weeks; his general condition improved so as to warrant making a radical operation, and under chloroform (second operation) the author exposed the hydronephrotic sac. After exposing the hydronephrotic sac, he found the ureter running along it, adherent to it, hooked over a small additional renal artery, and descending from this artery downwards, there being quite a sharp flexure at the point where the additional renal artery held the ureter up. The renal artery was divided between two ligatures, and the flexure of the ureter relieved.

On opening into this hydronephrotic sac through a two inch incision, and by turning it inside out with the finger, he found the ureter was no longer patulous. Then, by means of a Heineke-Mikulicz operation, like a pyloroplasty, the opening between the ureter and the pelvis was enlarged. An opening was made

by dividing the ureter and pelvis for three-quarters of an inch longitudinally, and uniting them by stitches.

An interesting point was the position of the renal artery which was probably the cause of the hydronephrosis. The man had only one functioning kidney.

L. L. McArthur referred to cases which belonged to the group classified as the interstitial mycoses of the kidney. In these there was really not a suppurative process in the kidney, but a bacterial process involving the substance proper of the kidney, as seen sometimes in the microscopic sections presented by pathologists, with the bacteria stained in the substance proper of the kidney, the process being relieved by splitting of the capsule and free drainage of the kidney. Such an experience he has recently had in a case of colon bacillus infection of the right kidney, in which a pure culture was found, in which the temperature was so high (106° F.) and the chills so severe as to warrant surgical interference for the relief of the patient, who was suffering not only from toxemia, but from intense nephralgia. He was extremely chagrined to find no pocket of pus in the pelvis of the kidney, yet his patient improved from simple section, and opening of the pelvis of the kidney, with no stone found, no collection of fluid in the kidney, the kidney engorged to more than fifty per cent. of its own normal volume.

Daniel N. Eisendrath narrated the case of a boy who fell down a flight of steps and immediately afterwards had severe hematuria, which lasted for three days. He did not see the boy until two weeks later, when complaint was made of a dragging sensation in the right side of the abdomen, where the floating kidney could be felt. In consultation with E. W. Andrews, he cut down upon the kidney, and found it was displaced below the pole. The hilus of the kidney was about the level of the umbilicus, and the kidney was anchored in place. The boy developed traumatic neurasthenia, and passed from under his observation. Here was a distinct traumatic displacement of the kidney. One could see hemorrhages into the perirenal tissue at the time of the operation.

E. Wyllys Andrews contributed a paper entitled *The Drowning of Patients in Fecal Vomit during Operations for Intestinal Obstruction and Septic Peritonitis*.

The essayist stated that his attention was called a few years ago to a kind of accident hitherto unknown to him, namely, the loss of life by drowning in fecal vomit, and he reported two such cases at a previous meeting of the society.

A patient may be killed by drowning in fecal vomit while unconscious on the operating table or semi-unconscious after anaesthesia. The utter collapse which follows ileus of any origin favors this accident of flooding the air passages, so that it probably occurs rather often. He did not wish to invoke this as a sole cause of sudden death or to ignore such other causes as toxemia, myocarditis, embolism or pulmonary edema, but he described two plain cases of death by suffocation which he had seen himself.



After reporting these cases, several members of the Society brought him verbal reports of similar deaths which they had personally seen. Dr. Andrews drew the following conclusions:

1. Flooding of the air passages by fecal vomit is a real danger and probably has caused many unexplained deaths.

2. Resuscitation is impossible or very difficult.

3. The fluid may flow by gravity through the relaxed stomach, sphincters, directly out of the intestine, where it has accumulated in large quantities.

4. The accident occurs with great suddenness and with a stomach supposedly empty. The suffocation may be so complete that no outcry is made, and may not be noticed by the patient.

5. It may occur as late as an hour after anesthesia, or at any time until consciousness is restored.

6. We have no evidence that it can occur during consciousness even in extremis.

7. After septic laparotomy patients when returned to bed should be watched without even momentary intervals to full consciousness.

8. A suggestion made to him by Dr. McArthur, that as many as possible of such cases be operated under cocaine anesthesia seems to him sound in the light of the above report.

#### Pharyngo-Laryngectomy.

A. E. Halstead exhibited a specimen of larynx, pharynx and tonsil, which he removed last April from a man at the Chicago Polyclinic Hospital. The patient was forty-five years of age. The carcinoma started in the larynx just above the vocal cords, and involved the epiglottis, pharynx and tonsil. The first operation was a preliminary tracheotomy, which was done because of the dyspnea from which the patient was suffering. This preliminary tracheotomy was not performed by himself. It was three weeks later before the radical operation was done. The trachea was plugged by the Trendelenburg balloon canula, and as soon as the trachea was cut through, the canula was removed and an ordinary tracheotomy tube inserted. The anæsthetic was given through this, the previous tracheotomy opening having been plugged. The larynx was completely separated, together with the anterior wall of the esophagus, the side of the pharynx, the tonsil, half of the hyoid bone and epiglottis. A plastic operation was performed on the anterior wall of the trachea, and the wound closed. A stomach tube was introduced and fastened at the upper angle of the wound. The second day after operation the patient became delirious, tore out the stomach tube, and opened up the wound. He made a very fair recovery from the operation, was up and around at the end of a week, and lived for eight months. The patient died from pneumonia caused by exposure.

Daniel N. Eisendrath reported a case of Abscess of Steno's Duct, with Plastic Operation on the same.

#### The Physicians' Club of Chicago.

Stated meeting, Feb. 23, 1903, H. B. Favill presiding.

#### Subject: "The Prevention of Tuberculosis."

W. A. Evans opened the discussion, considering "the Reasons for a Special Effort to Prevent the Spread of Tuberculosis."

He said that three reasons were to be comprehended under that title. First, that the subject of itself is worthy of consideration by this or any other body, whether medical or lay; second, that there is no special reason for efforts at prevention unless there was some hope that that effort could be or would be successful; third, that there is reason for special effort, in view of the fact that it will not prove unavailing. Discussing the first of these reasons, he said that tuberculosis still remains the chief source of death and the subject of prime consideration. In Philadelphia, during the census year of 1900, tuberculosis was responsible for 11.5 per cent. of the total death rate; in New York State for 10.6 to 11 per cent.; in Greater New York, for 7,919 deaths; in Chicago, for 2,700 deaths, or 9.5 per cent. of the total death rate; in San Francisco, 1,049 deaths, or 16 per cent. of the total death rate. In the ten principal cities of this Country, tuberculosis is responsible for 18,763 deaths, or 10.8 per cent. of the total death rate each year. Compared with other infectious diseases, which receive greater attention in the matter of prevention than tuberculosis, the relation in Chicago to diphtheria is four to one; scarlet fever, 7 to 1; typhoid fever, 7 to 1. Consumption kills in Chicago each year one and two-thirds times as many people as diphtheria, scarlet fever, typhoid, smallpox, measles, and meningitis combined. A comparison of the death rate from these diseases in the ten principal cities of this country shows that 18,763 die of tuberculosis, and 12,261 die of typhoid, scarlet fever, diphtheria, measles and whooping-cough combined.

Another point worthy of consideration is the approximate money cost of tuberculosis. Although pneumonia is a frequent disease, yet the patient is sick for only a short time, and is a relatively small tax on the community. The subject of tuberculosis, on the other hand, is sick on an average of from one and a half to three years, and during much of this time is a heavy tax on the community. According to Vaughan's estimate, there are one and a quarter million tubercular subjects in this country. At \$1.16 cost to the community, which is not a high figure, the annual cost of tuberculosis is \$700,000,000. Biggs, of New York, estimates that the cost in this country is \$350,000,000. Prior to the spurt in industrial activity, the total money paid during the last five years for exports was only \$800,000,000.

Kohler's statistics show that between the ages of 15 and 60, one-third of the people die from tuberculosis. According to Bertillon, 76.1 per cent. of all people who die from tuberculosis die between the ages of 20 and 60. According to Biggs and Prudden, there are in the City of New York at any given moment twenty thousand people who are rendered unproductive by reason of this disease.



*Compared with Pneumonia:* The Health Commissioner of the City of Chicago called attention to the fact that pneumonia was becoming more important than tuberculosis; that the death rate from pneumonia is increasing. Tuberculosis, on the other hand, is decreasing. The speaker called attention to the inaccuracy of comparative statements that are published now and then, in which comparison is made between the death rate of today and that of forty or fifty years ago. The diagnosis during those decades was not accurate, and therefore a comparison is of no value. The statistics of 1880 show that there is a slight decrease in the death rate from tuberculosis, but there is a decrease also in the death rate from every other disease, with the exception of pneumonia. The decrease in the death rate from tuberculosis is not commensurate with the decrease in the death rate from other diseases, that is, infectious diseases. Looking at it from this standpoint, there is a relative increase in the death rate from tuberculosis, and it becomes a question of growing rather than declining importance.

Can tuberculosis be cured? According to the statistics compiled by Dr. Appel, U. S. A., in charge of Fort Bayard Sanitarium, 7.4 per cent. of cases are clinically cured; 11.6 convalescent; 34.9 improved; 25.2 unimproved; 20.9 per cent. die. The United States Army Hospital is required to take tuberculosis in all stages, and a considerable number of cases that figure in these statistics are people who die before they have been in the institution one month. Again, these people in many instances are syphilitic, and, in most instances, alcoholics, which would, of course, influence the statistics. By the term clinically cured is meant those cases that no longer have fever; cough; no bacilli in the sputum, and that no longer react to tuberculin. The statistics of the Government Hospital at Fort Stanton, in charge of Dr. Carrington, show that 24 per cent. are apparently cured; 53 per cent. improved; and that 23 per cent. die. Of cases in the early stage, 66.6 per cent. are apparently cured; 30 per cent. improved, and 3.3 per cent. die. In the second and third stages, 13 per cent. are apparently cured; 51 per cent. improved; 3 per cent. unimproved, and 26 per cent. die. Latham, in a study of the statistics of 44 sanatoria, found that the average of cures is 30.6 per cent., and the average of improved cases 71.4 per cent. From a study of the statistics of the German Insurance Office, embracing twenty thousand cases, it is seen that 70 to 80 per cent. are apparently cured, and 40 to 43 per cent. permanently cured at the end of three years.

As further evidence bearing on this question, Dr. Evans cited autopsy statistics. He did not agree with the statistics of Bouchard and Ribbert, who claim that healed lesions are found in from 75 to 100 per cent. of people dying from diseases other than tuberculosis. Nor does he agree with Massini and Bollinger, whose figures range from 27 to 39 per cent. The truth lies somewhere between Hertler, who gives 4.7 per cent., and Latham, who gives 22 per cent. Osler says 7.5 per cent. as the result

of one thousand post-mortems. Wethered gives 10 per cent. Knopf agrees with Latham.

As to the possibility of a permanent cure: According to Baldwin, the majority of 115 cases remained cured for from ten to fifteen years. Knopf says that the majority of those discharged as apparently cured are not actively tubercular at the end of three years. The statement is made that those who have tuberculosis constitute but a small part of the problem. The important problem is, what shall be done to prevent people from becoming tubercular? Every tubercular subject is, in a certain measure, a focus of infection; the spreader of tubercle bacilli. Thirty per cent. of all deaths are from diseases of the lungs. The question of prevention of tuberculosis resolves itself into three parts: Hygiene, general hygiene, and ventilation. The lungs are important excretory organs, and while we would not for a moment think of using the excretory products of the kidneys or bowels, we do not hesitate to use and re-use the excretory products thrown off by the lungs. The question of prevention of tuberculosis has to deal with general hygiene, personal hygiene, house hygiene, and air hygiene.

The speaker called attention to the work of Behring, who is attempting to produce artificial immunization in animals. Some years ago Dr. Klebs called attention to the fact that leprosy at one time was widespread in Europe, just as tuberculosis is today, and that since special efforts, as we propose to use now in the case of tuberculosis, were made to prevent its spread, the disease has disappeared almost completely in Europe. There is no reason why this should not be true also of tuberculosis. Prevention must be effected, not alone by the medical profession, but by the laity, the people at large, who are most directly concerned and largely responsible for the spread of this disease. Laws are the result of public action; public action is slower than public conscience, and public conscience lags far behind public intelligence.

The next topic, "In What Way Can the General Practitioner Assist in the Purposes of the Crusade?" was considered by N. S. Davis, Jr.

He said that the position of the general practitioner in this movement is educative, but his influence should not be limited to educating his patient only. The hygienic treatment of tuberculosis is the only treatment that holds out any hope of permanent recovery. It is essential, then, that we educate those about the patient, those who must be associated with him. The patient should live in light rooms, where there is good ventilation, and where the surroundings are clean and hygienic. It is impossible to maintain cleanliness in a dark place. Therefore, these patients should never be permitted to occupy dark rooms that are poorly ventilated; that receive no sunlight or even daylight. We must teach our patients and their friends that the rooms must be thoroughly ventilated; that they must not be afraid of draughts; that there must be fresh air. It is better to stand the risks of exposure

to draughts (which are small) than to constantly respire foul air.

Patients and their friends should be taught to collect and destroy the expectorate. This should not be overlooked at any time. There is one point that is oftentimes overlooked by the practitioner, and that is, that patients can be taught to suppress a cough. When coughing is accompanied by expectoration, it should be promoted, and not suppressed, but much coughing is done not for the purpose of expelling something from the air passages, but to relieve a tickling in the throat. Such a cough can and should be suppressed. The little spray thrown out by the effort at coughing contaminates the air and walls of the room, and may be the source of infection. These rules are of benefit to the patient, but particularly so to those who come in contact with him, by preventing contamination. The importance of following these rules can be made more apparent by telling the patient that he is liable to re-infect his own lungs in new places by constant reinhalation of bacilli from the air.

The belief has gained ground among the laity that tubercular patients should be shunned. The relatives of tubercular patients often are afraid to be near him for fear of contracting the disease. As a matter of fact, there is no danger in being near a tubercular patient, providing the rules laid down above are faithfully carried out. It is not so much the individual as it is a lack of cleanliness; the failure to maintain clean, well-lighted, well-ventilated rooms, and the careful gathering and destruction of the expectorate. It is important, therefore, that we educate those about the patient. Unfortunately, the physician does not have the opportunity, nine times out of ten, to educate his patients, and those about them, along the lines laid down above. Usually the patient is seen now and then in the physician's office, where the strict observance of these rules cannot be enforced sufficiently. It is necessary to come in closer relationship with these individuals, and this can be accomplished with a greater degree of certainty through public efforts rather than private efforts. In line with this, the speaker called attention to the necessity of having attendants for these patients who are educated to take care of tubercular cases. There is also a need for places where patients can be educated to take care of themselves; where they can be taught by object lessons, seeing others who have improved under proper hygienic surroundings. Every hospital ought to set aside space for tubercular cases of all kinds. Today there is scarcely a hospital in Chicago which is willing to take these cases, because they are not prepared for them. That is wrong to the patient and to the community. Patients in the early stages of the disease, if intelligent, can be taught readily what they should do, and they also will carry out the rules laid down for them, because they can be made to understand the necessity for these rules. Unfortunately, however, the majority of cases occur among the ignorant, and the careless; those who cannot or will not observe

these rules unless forced to do so. The patient should be placed in an institution where in the course of a few weeks or months he can be taught properly. The hospitals should have a place for patients in the earlier stages of the disease, and also for those in the advanced stages. Unfortunately, the hospital attendants and managers, like the laymen, have become fearful of these patients. This is especially true of the surgeons. If these patients were admitted to the hospital, they would do no more harm, if placed in a ward by themselves and cared for properly, than any other class of patients in the hospital. We do not hesitate to admit patients suffering from epidemic influenza, a disease more easily transmitted than tuberculosis. We admit patients suffering from croupous pneumonia, a highly infectious disease. Tubercular patients should have parts of the hospital set aside for themselves exclusively.

There is another advantage to be gained by admitting tubercular patients to general hospitals, because we will then have nurses educated to take care of this disease. As it is, we have none. Our trained nurses have had no experience in the care of tubercular patients. We need nurses who have had special training in this direction. He believes that the statistics read by Dr. Evans would be changed materially if our nurses were educated to take care of tubercular patients as they are to take care of typhoid fever and pneumonia. This is one of the most important points to be considered in the matter of prevention of tuberculosis. If we had trained nurses who are capable, who understand fully how these patients should be cared for, who would see that all the rules would be carried out long enough to get the patient in a better state of health, so that there would be little danger of infection of others, a great step would be taken to cut down the death rate from tuberculosis as well as the number of living cases. The physician rarely comes in contact with a patient's friends and relatives, whereas the nurse comes in contact with both all the time. She can point out the advantages as the physician can not. Just so soon as this knowledge can be disseminated through the community, the community will perceive the necessity for observing hygienic rules. They will appreciate the necessity of thorough ventilation in the street car, public conveyances of all kinds, theatres, churches, downtown stores, etc. These are points the public does not appreciate thoroughly, nor can it be made to do so until educated much more perfectly than it is today. In the dissemination of this knowledge, the physician is comparatively impotent, but he can inaugurate a system through which this information can be spread widely and thoroughly and there is no one more fitted to do this than the nurse. Give us nurses who are trained to take care of tuberculous patients. They should not form a class by themselves, but every trained nurse should have experience in the care of cases of pulmonary tuberculosis, just as she has in typhoid fever, pneumonia, or any other disease.



A. C. Klebs considered "Outlines for a Systematic Crusade in this City."

The committee on the prevention of tuberculosis of the visiting Nurses Association in Chicago. By A. C. Klebs, M. D.

Several years ago the necessity of a special movement against tuberculosis as a public menace was recognized by several medical men of this city. A general movement in this direction had just been inaugurated in England under the highest patronage and following the initiative of Germany. This example was followed here by the foundation of the Illinois Society for the Prevention of Tuberculosis, suggested by the health commissioner Dr. Reynolds at a special meeting of the Chicago Medical Society. This was all that was ever done in this direction in Chicago, neither the public nor the profession at large could be sufficiently interested to help in such a work. In the meanwhile the movement especially abroad and also in some cities of this country has taken definite shape and the necessity that something ought to be done here has been realized by a wider and wider circle. Especially the charity organizations, who have to deal with a great number of consumptive poor awoke to the necessity of systematic procedure in such cases. The visiting nurses association founded a special committee to investigate the question and to devise a plan of action. At first it was contemplated to form a new society with a large membership, the members to contribute to the expenses of the needed measures. After some consideration this plan was abandoned and it was deemed advisable to first arrange the work under the auspices and direction of a committee of 40, which later on, perhaps after one year shall form the nucleus of a new society. This course, it is hoped will allow us to study carefully the local conditions and make us acquainted with special requirements, before we ask the public at large to join and contribute. The committee of 40 is composed of representative citizens and physicians, the executive work to be carried on by a sub-committee of six (three laymen and three physicians). The Visiting Nurses Association, to start the work, has very generously appropriated the sum of \$2,000 to meet immediate requirements of this committee and the Bureau of Charity has offered the use of its district offices for its purpose. Here we have the working basis for what we hope will prove a most efficient campaign against the spread of the disease amongst the poor.

The outline of the work as approved by the committee is as follows:

**In General:** Considering the fact that the family-members of a consumptive and those living in unhealthy conditions are the ones most threatened by the disease, education on the subject and eventually proper material aid has to be furnished to them primarily. The distribution of instructive pamphlets alone usually proves insufficient, it is therefore necessary to enhance the value of such printed instructions by personal interview and repeated visits. For this purpose the co-operation of specially trained physicians and nurses, with the assistance of charity organizations is deemed of im-

portance. To facilitate such co-operation and to insure the uniformity of the measures to be employed it is planned to establish a central office. From this office the general work is to be directed and carried out in district offices in the different parts of the city.

**In Detail:** (1) The work in the central office is to be done by an **executive committee** of six to be elected from (2) the **general committee** of 40, of which 12 are to be physicians. (3) A special "Tuberculosis Fund" may be established if necessary. (4) Work to be done in the central office:

I. To collect and file all information regarding tuberculosis in Chicago. To ascertain the causes for the greater prevalence of the disease in certain districts. Examine the conditions of life of the people in those districts and especially the condition of dwellings. To start a collection of literature on tuberculosis especially in its social-economic aspects. To maintain correspondence with other organizations with similar purposes.

II. To prepare instructive reading matter on the subject, for distribution amongst the public, especially on:

1. How to avoid contracting tuberculosis (consumption).

2. Predisposing causes of tuberculosis and how to avoid or overcome them.

3. Letter to store keepers and manufacturers, telling them how they can best help the cause.

4. Letter to hotel keepers on the same.

5. Letter to school teachers and superintendents on the same.

6. Instructions to nurses as to how to proceed in cases of tuberculosis in the different stages, what to do for the other members of the family, etc.

7. Instructions to district physicians: (a) which cases to treat and how, (b) which cases to report to central office, (c) what details as regards hygiene and sanitation, are to be investigated in a consumptive's family.

8. For District Physicians: Classification of tuberculous cases according to the physical findings:

a. Extent of disease.

b. Degree of virulency.

c. Duration of disease.

d. Prognosis.

9. A popular treatise on the subject of tuberculosis, explaining the exact degree of the danger of contagion and emphasizing the importance of predisposing factors. Also an outline of the measures inaugurated in Chicago.

III. To make arrangements for public lectures on topics of tuberculosis and public and individual hygiene in all parts of the city. Also to induce the press to give publicity to such topic.

IV. To co-operate with the health authorities and charity organizations in the enforcement of measures which will promote public hygiene.

V. To see to the disinfection of houses in which consumptives have died and to ascertain the most efficient and practical methods, which will accomplish this.

VI. To procure information about healthful



occupations for the employment of persons, working under unhygienic conditions, eventually furnishing them such positions.

VII. To decide on the advisability of transferring persons attacked with or predisposed to the disease to other climates, eventually providing them with positions abroad.

VIII. To plan, found and eventually maintain health farms for convalescing or predisposed children, sanatoria for curable cases and hospitals or homes for advanced cases.

IX. To advance the introduction of modern methods in existing institutions, receiving consumptives.

X. To test new ideas in the treatment of the disease, which promise results.

XI. To supply the needy with food, medicines, disinfectants, spit-cups and articles which will promote conditions of hygiene and cleanliness in their homes.

XII. To extend aid to all efforts at organizations for the prevention of tuberculosis and to stimulate activity in this direction everywhere.

XIII. To examine all cases applying for help and treatment at the office or in their homes and to decide upon the most efficient procedure in such cases, for their own as well as for the benefit of their families.

XIV. To facilitate and increase the radius of such work by the foundation of district offices, wherever they may be needed. Each office to have one or more physicians and nurses in charge, which will carry on the work, as outlined by the central office.

This outline of work offers nothing especially new, it is simply an adaptation to similar work done elsewhere, still we believe we have insured its greatest efficiency by the consolidation of those charity organizations, which most intimately come in contact with the classes we wish to reach. To carry out all of the desiderata, in this plan will need a considerable capital, but for the beginning it was thought best to refrain from a general appeal for financial aid. When once we can prove and formulate in what direction the expenditure of money will best help the purpose of the organization, we are confident that financial aid will not be withheld. For the present the purpose is to apply experiences gained elsewhere to the function of existing organizations in a systematic and uniform way. All the charity organizations in this city have to deal constantly with numbers of consumptives; the disease has laid up the one bread-earning member of a family, it has either completely incapacitated him or only partially so, or another has fallen victim to the disease, leaving behind a family, not only robbed of material means of support, but very frequently most markedly predisposed to the disease. There are numerous problems daily offered to them, which await solution and since the number of opinions on what to do in those cases are usually as numerous as the number of people consulted, considerable confusion is the result, both charity organization and the applicant being the sufferers.

Most of such questions, it is planned ought to find their solution in the district offices. The Bureau of Charities has already offered their

offices for this purpose in eleven different districts. It is planned to put these offices in charge of physicians, interested in this special subject, later on these positions shall bring a salary. The physician in charge of these offices, of course can always consult with the central office and has at his disposal the services of the visiting nurses and the visiting staff of the Bureau of Charities. Later on it may be found of advantage to have one visiting physician attached to the district offices; all situations which cannot be adjusted in the district offices are referred to the central office. Here also those actively working in this organization are to meet at frequent intervals and all points of importance are to be discussed.

It was considered better to start a separate dispensary system throughout the city, instead of utilizing existing medical dispensaries, for the reason that it probably will simplify the work. The medical dispensaries supply only medical aid, while here material aid as well shall be supplied and always with the point in view of promoting domestic and individual hygiene. It is of course impossible to lay out general rules which will meet the requirements of every case and it is just for that reason that it was thought best to distribute the workers over a wide district, so that the conditions can be investigated on the spot and treated accordingly.

We all realize fully that we cannot stamp out tuberculosis in any given time, perhaps we will never be able to, on the other hand we know that the appalling prevalence of the disease is due to unhygienic conditions in the houses, even more so than to the wide dissemination of tubercle bacilli. The successful treatment of individual cases is accomplished also on hygienic-dietetic lines, best so in sanatoria, and it is to be hoped we will have such institutions also in this city. Their greatest value is through education of the patients treated, and indirectly of the family. As long as we do not have sanatoria, we must use sanatorium methods in the houses of the consumptive. Ambulatory treatment of such patients by such principles has proved quite successful in other cities and compares favorably with that of sanatoria. But the plan, just outlined, is meant to develop its highest efficiency not by the care of individual cases, but by applying the principles that bring about a cure and are preventative at the same time, directly where most needed. It is in short an educational campaign for domestic and individual hygiene by practical and scientific methods. It must be clear to every one that the principles to be applied are not preventative of tuberculosis only, but of any other disease, and in this way a movement in this direction increases its importance necessarily. To make it successful everyone physician and layman ought to be interested to learn about it and to help it in every possible way.

#### General Discussion.

Robert H. Babcock said that whenever tuberculosis has been diminished, it has been through intelligent effort of the medical profession, and especially by bringing to bear the influence of public health boards. This has been proven in New York City, where there has been a very gratifying decrease in the death rate from pul-

monary tuberculosis, in spite of the fact that at first the medical profession was rather antagonistic to the work. Physicians were requested to register cases of tuberculosis, but failed to comply with this request. The first step in this educational movement should be the education of the medical profession. Many physicians are entirely oblivious to the necessity of preserving proper hygienic measures in cases of tuberculosis. They should be forced to see the importance of these measures. They should educate the patient and his attendants. The physician is not able merely to influence his immediate patient; he is a small lump of leaven which can leaven the whole mass, and every physician should be impressed with the fact that he can influence people and educate them, not only in the needs of prevention, but in the ways in which prevention can be procured.

The medical profession should endeavor to secure proper legislation along these lines. If this work is to be carried on successfully, it must not be done by a handful of devoted men, but the local and State health boards should be given powers which will enable them to combat successfully this disease. The local board of health is more or less hindered in its ability to adequately cope with this disease. It has not the power to carry out measures of disinfection, to say nothing about registration of these cases. This power must come through the State Legislature. This body must be shown the necessity for establishing public sanatoria and hospitals throughout the State for the care of consumptives. The profession can do much in the way of enlightening and educating men of wealth to turn the current of their charity toward the establishment of such institutions. If these gentlemen could be impressed with the fact that their wealth would do more in benefiting mankind in a physical way rather than in an educational way, we would have made a long step toward securing some of these institutions, which we all feel are so necessary to the prevention of tuberculosis.

Walter M. Fitch called attention to the susceptibility to infection, a point that is usually overlooked by the profession. The entire bronchial tract is lined with ciliated epithelium, which is constantly vibrating, and throwing out foreign material from the air passages. When the lungs are fully expanded, these cilia operate perfectly, sweeping clean the mucous membrane from any disease germs which may lodge upon it. If, on the other hand, there is partial collapse of these bronchial tubes, due to imperfect expansion, pockets are formed into which the germs are drawn, and where they remain. The cilia cannot remove them. Many individuals are growing up with a subnormal development of the chest. Obstructions to respiration in the form of adenoids and enlarged turbinates are overlooked in childhood, and children grow up with a contracted chest, the result of subnormal respiration. They are susceptible to lung infections. A well developed active chest is not susceptible to such infection, and much can be done to overcome this susceptibility to the disease.

George W. Webster said that in con-

sidering the tuberculosis problem, two factors are to be considered: One, the germ, and the other, the susceptibility of the individual. As it is impossible to destroy all the tubercle bacilli, it is necessary to take every precaution toward prevention of the disease. The form of chest and the type of tissue in which the disease is prone to develop do not receive sufficient recognition. In some families individuals with special predisposition to tuberculosis in the way of deficient expansion of the chest are found, and these individuals should be impressed with the necessity for proper hygienic training. They should be informed of the predisposing factors to tuberculosis, and urged to live in hygienic surroundings, to take proper exercise, to observe cleanliness, temperance, and to aerate the lungs perfectly. The importance of institutional treatment should be dwelt upon. Institutional treatment is of value for a number of reasons, but chiefly because it teaches these patients their duty to themselves, their duty to their family and their duty to the public. Second, institutional treatment is of value because it removes these persons from their home surroundings, and in that way removes a focus of infection. Further, each patient when he returns home becomes an educated center, from which accurate information is disseminated.

The speaker agreed with Dr. Babcock that physicians are not doing their duty in teaching their patients and warning them of the dangers of the disease; the safest way of living with it; the best methods for preventing its spread in the family, and outside. The average practitioner does not give his patients thorough instruction on these points. Usually, he writes a prescription and that is all. The education along this line should begin with the physician. In the public schools, high schools, academies, colleges, and universities, more time should be devoted to the teaching of public hygiene, especially the prevention of infectious diseases, tuberculosis in particular. More time should be given to such teaching and less time to music and studies of less value.

He emphasized also the importance of proper legislation, which is essential to carrying out proper methods of prevention. He urged upon the profession the necessity for taking steps to defeat a bill now pending in the Legislature, whose purpose it is to repeal the so-called "birth and death bill." This birth and death bill is the first great step in medical legislation taken by the State of Illinois. Likewise, steps should be taken to promote the establishment of a State sanatorium for consumptives. Every physician should do all he can in this direction; it is a duty he owes to himself, his patients, and the public at large.

Dr. Webster expressed his appreciation of the plan proposed by Dr. Klebs. He considered it eminently practical, and sufficiently elaborate to meet all the requirements of the case. In conclusion, he offered the following resolution:

"Resolved, That it is the sense of the Physicians' Club that its members heartily approve and endorse the plan proposed by Dr. Klebs for preventing the spread of pulmonary tuberculosis."



L. Harrison Mettler called attention to the fact that the laity, even the more intelligent, do not look upon tuberculosis as a contagious disease. He suggested that properly guarded articles be given to the public press, journals and magazines, for the purpose of educating the public. The public, as a whole can be reached better through a daily paper than through any other medium. He endorsed the plan proposed by Dr. Klebs, of giving public lectures on the prevention of tuberculosis. They would bring the information directly to the people, who should be impressed with the fact that tuberculosis is communicable, although not in the same sense as is scarlet fever.

A. M. Corwin said that the element of depressed tissue resistance did not receive sufficient recognition in this matter of susceptibility to tuberculosis. He referred to the poor architecture, from the standpoint of hygiene, of the modern building. The atmosphere in most of them is of the foulest, because of insufficient ventilation, and poor lighting facilities. These surroundings have a very depressing effect upon individuals who are obliged to spend much time in them, and could not do otherwise than create a susceptibility to tuberculosis. He suggested that it would be an interesting matter to ascertain what proportion of cases of tuberculosis come from this class of people, this poorly vitalized class. The dust-laden atmosphere in these buildings produces a primary inflammation of the pulmonary tissue, thus affording a suitable medium for the lodgment and growth of the tubercle bacillus. This matter is of equal importance with the proper hygiene of the home or the hospital.

A. C. Klebs said that he believed the public would resent any intrusion by public health officers in a disease which affects the victims rather slightly. Legislation would probably necessitate such an intrusion, and give rise to conflicts with authority. That is one reason, probably, why the health boards have been unable to do more than they have in the prevention of tuberculosis. This is also the reason why the registration of tubercular cases was objected to, and although this would be an ideal measure, yet it cannot be carried out. Another thing that should be done is thorough disinfection of the dwelling occupied by a deceased tubercular patient. That would be of great assistance in prevention. A private movement will be more successful than one instituted by legislature. The poor people appeal for physicians, for nurses and to charity organizations, and through these channels they can be instructed and educated. The health department cannot do this, because they would have to reach these people through official health officers, and that would be obnoxious to the community. If we had as good an organization here as in New York, we could probably do something. We cannot get politicians to appreciate the importance of hygienic organization sufficiently to carry out these measures. A private movement can do no harm, and may be of considerable assistance to the health department in the prevention of tuberculosis.

John A. Robison said that it was his opinion that physicians should criticize any shortcomings

of the city or State government in carrying out proper hygienic measures. Much could be done if pressure were brought to bear on the city officials, so that they would give the local board of health more power to carry out proper sanitary measures, not only with regard to the prevention of tuberculosis, but also the prevention of other infectious diseases. He commented favorably upon the work done by the Committee appointed by the Chicago Medical Society to investigate the conduct and management of the hospital for consumptives at Dunning.

L. Harrison Mettler,  
Official Reporter.

The Chicago Medical Society met Feb. 18, 1903, with the President Wm. A. Evans, in the Chair.

Mr. Hastings H. Hart, Superintendent of the Illinois Children's Home and Aid Society, read a paper entitled *The Illegitimate Child in Chicago*.

Among other things, he said that Chicago is the great dumping ground for the social wreckage of the interior. There is no city in the Union which suffers as much as Chicago from bearing the burdens which belong to other communities. There are sent into Chicago from all directions the lame, the blind, the sick, the insane, the dependent of all classes. In addition to the large number of young women resident in Chicago, thousands of young women come here from other communities to be delivered of illegitimate children. Some of these come without means to defray their expenses, in some one of the numerous lying-in hospitals, or in some one of the regular hospitals of the city. Many are found in private families or boarding-houses where they are cared for by some physician called in for that purpose. Many of these young women come to Chicago without means, and are cared for as objects of charity, either by the public, in the Cook County Hospital, or by private charity through some one of the various homes or societies, or by private generosity.

The physician more than any other public servant is the guardian of the sexual morals of the community. His relation to his patient is such that he is able to exercise a potent influence at the time when it is most needed. Many a young woman has been rescued from dire peril and has become a good wife and mother through the wise and timely intervention of a faithful physician. He can do what neither parents, clergymen, nor friends can do. He is invariably consulted and his advice is usually followed. A great responsibility rests upon him, because he practically controls the policy of the community in dealing with this important social question.

Four parties are to be considered: The child, the mother, the father and the community, including relatives and friends. He first considered the interests of the child. It is the duty of the physician to see that the child's life and health are properly guarded before and after birth. It is not enough that he should refuse, as every honorable physician does, to have anything to do with efforts to destroy



the life of the child before birth. It is his duty to throw the whole weight of his influence, personal and professional, against the commission of this crime, and to warn the young mother and her friends not only of the perils to her life and health, but also to the wickedness of this offense. If the mother is physically capable, she should invariably be required to nurse her child. From mistaken kindness, the mother is often dissuaded from nursing the child lest she should become attached to it and suffer greater pain from the inevitable separation. Sometimes the mother is not even allowed to see the child lest the maternal instinct should be aroused. In other cases the mother is encouraged to wean her baby and board it out in some home or baby farm, in order to become a wet nurse at \$8.00 or \$10.00 per week; and her own baby is robbed of the nourishment which rightfully belongs to it, and perhaps loses its life in order that the baby of a more fortunate mother may be preserved.

The second party to be considered by the physician is the young mother. Most physicians stand ready to furnish their professional services without recompense, and to see that she has proper physical care as long as she is in the physician's hands. Theoretically, the doctor's duty ends at this point; but in many cases the physician finds himself, with or without his consent, involved in a responsibility for the future of the young mother. He has been the recipient of her confidence, and is the object of her gratitude. He, more than any other, has the right to say, "Go and sin no more." His advice would influence her more than that of any other. It is therefore proper that he should consider what course is most likely to quicken her penitence, and to lead her back into pure and womanly character. In a few instances it is practicable for the young mother to meet her maternal obligations by working outside, and paying board for the child in a suitable family. Such instances were cited. Formerly there was a great deal of trading in infants. There were individuals and societies who made a business of disposing of unwanted babies for a consideration. This sort of work has come to be recognized as discreditable and immoral. Whenever it is recognized that an illegitimate child can be disposed of for a price, without disagreeable questions being asked, one of the safeguards of public morals has been removed.

As to the third party, it is almost a universal rule that while the father of the child is the chief offender he suffers least of all. It is highly important, for his own sake as well as for the sake of the mother and child that he should be brought to face his obligation, and to meet it as far as he is able. If he goes scott free the chances are that he will betray other girls. If marriage is not practicable, the father should be persuaded or compelled, if possible, to make suitable provision for the mother and child. Under the laws of Illinois, the father may be compelled, if able to make provision, up to the sum of \$550.00; but in practice comparatively few fathers are made accountable. The mother is deterred from

taking legal steps, sometimes on account of affection for the father, more often on account of her unwillingness to subject her own name and that of her family to the ignominy which attends bastardy proceedings. In such cases the mother should be advised to secure the counsel and assistance of some good lawyer of mature years. Such a lawyer, by the use of vigorous pressure, can often secure some adequate provision for the mother and child without public court proceedings.

Mr. Hart then considered the fourth party, namely, the community, including the parents and friends of the offenders, the multitudes of young people who are exposed to like temptation and the charitable public. Every increase of faithful, conscientious and intelligent treatment of this subject on the part of those of us who stand in the position of guardians of the public morals, tends to diminish the heavy burdens which rest upon the good people of the community and toward the uplifting and purification of the body politic.

Sarah Hackett Stevenson opened the discussion, saying that the greatest victim is the child itself. Parents are more or less voluntary in the thought of their arrangements for the children, and she thinks physicians have a great responsibility placed upon them. Physicians think too little of these sociological questions, and consider their duty done if they write prescriptions and attend to patients. Frequently the physician is the first person who is consulted, and she regrets to say, from her own experience, that sometimes physicians through false education are allowed to give dangerous advice in these cases. Parents should be given to understand and realize that they alone are responsible for the lives of their own children. If they were so impressed, it does not seem to her there ever could be this excessive iniquity that is going on in our midst. She believes that members of the medical profession owe it to themselves, to the community and to their patients to stand right on this question.

Joseph B. De Lee stated that he had had a very large experience with illegitimate children, this experience extending over a period of about nine years. He receives almost every week three or four letters from physicians out of town requesting aid in the disposal of illegitimate children. He started out impressed with the notion that every mother should bring up her own illegitimate child, but he has seen so many unpleasant experiences following that course of procedure that he gave it up. If he insisted on the woman nursing her baby and leaving her to care for it, he found out later that the child was disposed of in one, two or three ways. First, the child would be given to a baby farm; second, probably put on a doorstep; third, the child would be sent to St. Vincent's or some other orphanage. The mortality of children in orphanages and baby farms is approximately ninety-nine per cent. As long as society recognizes a difference in the morals of the two sexes, he believes the problem is not going to be solved, and any efforts that are going to result in the ultimate solu-

tion of the problem of the illegitimate child must begin on the male side.

**L. Harrison Mettler** endorsed the remarks of Dr. De Lee. He feels that the question of the illegitimate child is an unsolvable one, until it is approached from the other side. The man has got to be held by society as morally responsible for his life as much as the woman. If a woman has an illegitimate child and is driven from her home, the father of that illegitimate child has equally degraded himself, and has no more right to enter one's home than has the woman, and if one was received into any home, the other should be.

**Mr. Hart**, in closing the discussion, said the cases are few in which he advocates the mother retaining the child permanently. He believes the mother should discharge her maternal responsibility for a sufficient length of time to give the child a good start in life.

The Chicago Medical Society held a regular meeting March 4, 1903, with Wm. A. Evans, President, in the chair.

#### Syphilis as a Cause of Chorea.

**L. Harrison Mettler** read a paper with the above title, and reported the following case, which he had seen in consultation with S. L. McCreight:

H. P., male, 11 years of age, born at full term, of German parentage, and showing at present unmistakable signs of inherited syphilis. The father, forty years of age, married about fourteen years, confessed to his wife and former physicians that he had contracted syphilis about nine or ten years prior to his marriage. He has had several hemiplegic strokes, has been in the insane asylum, and is now at home, a sad picture of irresponsible, harmless dementia, with paresis. The mother is without any signs of syphilitic taint, and denies having had any miscarriages. There are four living children, aged 12, 11, 9 and 5 years respectively, all showing more or less signs of inherited syphilis, such as ozena, skin eruptions, sore throat, diarrhea, Hutchinson's teeth, etc. The patient, who is the second child, appeared to be healthy until he was two years of age, when, without warning, he was taken with five severe convulsive seizures, one following the other in rapid succession, and all occurring within the space of a few hours. The mother supposed that these were attacks of simple infantile eclampsia, and so failed to note details as to the manner of their origin, continuation and termination. It was during these seizures that the boy's "eyes went wrong," as she expressed it, and left him with his present internal strabismus. Diplopia, of course, was present for a time, but now the vision of one eye is almost negative. The examination of the fundi a year or so ago by Dr. McCreight discovered nothing very abnormal. The shape of the head and development of the body show a well-marked condition of degeneracy. About three years ago the mother thought he had an attack of rheumatism, with heart failure. At present, however, there are no signs of organic heart disease. Scarlet Fever and measles are to be added to the history. After the convulsions at two

years of age, the left side became notably weaker and thinner. There has never been any repetition of the convulsions. At seven years of age the boy suffered his first attack of chorea. It seemed to be slightly more pronounced upon the left than upon the right side. The attack was, however, of the generalized form. Four attacks have occurred altogether, about a year apart, and each more severe than the previous one. Except the last one, they continued only a few weeks, and then gradually disappeared. This intermittence was almost, but not absolutely, complete; in the intervals there were occasional slight choreiform manifestations. The movements during the height of the trouble were all irregular, spasmodic, and incoordinated. They were typically choreic, and not slow or rhythmic, as in the so-called "symptomatic" chorea of the writers. They were partially under the control of the will and except upon the rarest occasions did not occur during sleep. They involved all parts of the body, the head, the face, arms and legs. It was quite impossible to use the knife and fork at table, and at times the movements were so strong and violent as to throw the patient from the chair or couch. There was nothing of an athetoid condition about the movements. The last and fourth attack or exacerbation began about ten months ago, was the most severe of any, and lasted altogether about four months. All the usual remedies for chorea failed utterly to modify the jactitations. The mental state showed a gradual weakening, and there were other signs of mental and physical exhaustion. There has been no cephalalgia. Complaint is made of indefinable, mild, shooting pains here and there about the body. Two weeks after beginning the administration of potassium iodide, there was a noticeable diminution in the jactitations, and in a week or two more they had ceased almost entirely. At present the child is well. The diagnosis made by the writer was symptomatic chorea, or rather generalized chorea with certain localizing symptomatic manifestations, due to inherited syphilis. The nature of the lesion can be imagined, but cannot positively be defined.

After discussing the nature of chorea, its possible dependence upon syphilis, acquired or inherited, and after showing how inadequately it is referred to by the writers in the books and current literature, the author formulated the following conclusions:

1. Syphilis, in rare instances, is a cause of chorea and should always be thought of as a possibility in the examination of every case.

2. Chorea may be the result of acquired or inherited syphilis.

3. Most of the cases of syphilitic chorea are unilateral, belong to the so-called symptomatic, pre or post-hemiplegic type of the disease; may or may not be associated with other signs of an irritative lesion; are not infrequently developed in hereditary syphilitics, and are to be attributed probably to a functional disturbance of an irritative sort in the cortical or ganglionic motor cells.

4. The existence and recognition of the two forms of syphilitic chorea, namely, the focal



and the generalized, supports the inference that all forms of chorea are but the expression of any one or more of a multiplicity of possible etiological factors, which may disturb the functional activity of the upper motor neurones, these factors being all the way from a gross lesion down to a molecular or chemical change not demonstrable with our present means of investigation. These conclusions lead to the corollary that chorea is not a disease, but merely a symptom.

5. When syphilis is decided upon as the cause of a case of chorea, that case should cease to be regarded as chorea, and should be promptly and thoroughly treated as syphilis.

Frank S. Churchill, in opening the discussion, said that the paper resolved itself into a discussion of the etiology of chorea. With reference to the connection between rheumatism and chorea, both neurologists and pediatricians agree that there is some connection between the two affections. It is interesting to notice the difference of opinion between neurologists and pediatricians as to the frequency of rheumatism in cases of chorea, occurring either before an attack of chorea, coincident with it, or afterwards. All neurologists place the frequency of rheumatism in choreic cases at about twenty to twenty-five per cent. On the other hand, pediatricians find a history of rheumatism in choreic children in from sixty to seventy-five per cent. of the cases. The reason is obvious, as when one reads an account of the disease as given by neurologists, he is impressed with the neurologist's conception of the word rheumatism. The neurologist looks at it from the point of view in the adult, whereas rheumatism in children is entirely different from that in adults. The neurologist looks upon rheumatism as purely a manifestation of an affection of the joints, whereas those who see many children know that rheumatism is a far more complex and varied disease than arthritis. Arthritis is not nearly as common a manifestation of rheumatism in children as is endocarditis. Cheadle, the first man who advanced this conception of rheumatism, says that arthritis is at its minimum, and endocarditis at its maximum, in the rheumatism of children. The view of Cheadle is now generally accepted as to the varied manifestations of rheumatism. So the speaker thinks the evidence is pretty conclusive that a rheumatic history can be found in about seventy per cent. of cases of chorea in children.

Albert H. Andrews, read a paper on the **Tuning-Fork and Stethoscope in the Diagnosis of Fractures.**

The test for fractures is based upon the fact that bone is an excellent conductor of sound waves, while the soft tissues of the body conduct sound waves very poorly.

The test for fractures, especially of long bones, is made by placing the stethoscope in close proximity to the bone near one end, and the handle of a vibrating tuning-fork as close to the bone as possible beyond the supposed seat of fracture. The sound will be transmitted through the shaft of the bone to the stethoscope and through the stethoscope to the ears of the examiner.

When the bone is intact, if the test is properly made, the sound of the fork will be heard with great distinctness, but if there is a solution of continuity the sound will either not be heard at all or will be heard very faintly.

By comparing the intensity of the sound on the suspected side with the sound heard under similar conditions on the normal side, the question of continuity of bone can be determined.

V. Pleth stated that last year he suffered with mastoid trouble and consulted the essayist, who, in examining him, employed the stethoscope and tuning-fork. Returning to his office, the speaker began to examine all the mastoids he could get a chance to work on, and conceived the idea of extending the method to the diagnosis of fractured bones by bearing in mind the well-known facts governing the laws of sound conduction through substances of varying density, and when broken. As demonstrator of anatomy at the Northwestern University Medical School last year, he made extensive experiments upon cadavers, afterwards extending his investigations upon the living. The method holds good in fractures of the long bones, but does not promise much in skull fractures in which the X-ray as yet seems to give the best results.

N. M. Percy said he could readily conceive how the tuning-fork and stethoscope may be of value to the otologist in diagnosing mastoid trouble, and he has demonstrated to his own satisfaction that they are of value to the general surgeon in the diagnosis of fractures. He examined with Dr. Andrews three cases of fracture of the neck of the femur, which he related. Since that time he has examined one other case of fracture of the neck of the femur, and elicited a distinct difference with the tuning-fork and stethoscope between the sounds of the unaffected side and the injured side. While the ends of the bone may be in direct contact, still the sound is not transmitted as distinctly on the affected side as it is on the sound side. He thinks it will prove a valuable means of diagnosis in fractures particularly of the femur and of the neck of the femur.

**Shock produced by General Anesthesia, with Relation to Disturbances of the Blood and Gastro-Intestinal Tract.**

Fenton B. Turck read a paper on this subject, in which he dealt (1) with the consideration of the anesthetic as a cellular poison; (2) the disturbances of function as the result of the anesthesia; (3) toxins that are evolved either from the direct effect of the anesthetic or the disturbances of certain functions of the body.

After narrating several experiments on animals with chloroform and ether, he stated that the conclusions that can be drawn from them are that where shock is produced, it does not materially differ from the shock that results from trauma. The most constant pathological factor is failure of circulation, and this is especially expressed in splanchnic congestion. Failure of temperature and respiration has been considered to be the result of the vascular failure, with a corresponding fall of blood pressure.



He drew the following deductions:

1. The circulatory disturbance is a direct result of the chloroform or ether acting upon the vaso-motor centers.
2. The effect of chloroform and ether upon the splanchnic circulation results in congestion.
3. The direct effect of the toxins of chloroform and ether acting upon cells, with disturbance of metabolism, may produce toxic products.
4. The resulting elaboration of toxins produces symptoms of auto-intoxication, associated with the formation of hemolytic and agglutinating bodies, and precipitins.
5. Indirect toxic effects result from retention of toxic products through disturbances of elimination.
6. There is lessened resistance of the blood serum to normal excreted toxins.
7. There is lessened resistance of the blood serum to bacterial toxins.
8. There is diminished resistance to the development of saprophytic and pathogenic micro-organisms.
9. This may be partly explained by the changes observed in the sera, such as hemolysis, agglutination, precipitins, etc.
10. The reflex effects result, such as reflex irritation set up by the excretion of the anesthetic into the stomach and intestines.
11. As the result of atony, there is the formation of toxins in the stomach and intestines through bacterial growth.
12. Atony of the stomach and intestines results in the accumulation of gases, and interference with the circulation.
13. There is increased toxicity of the stomach contents in the presence of chloroform and ether.

Daniel N. Eisendrath said this is the first paper which has brought direct experimental proof of what physicians have known clinically, namely, the toxic effects of both chloroform and ether upon the gastro-intestinal mucous membrane. Ever since the researches of Nothnagel and others, it is known that from a pathological standpoint both chloroform and ether produce grave disturbances of the parenchyma of the heart, of the vessels, of the unstriated muscle, of the alimentary canal, of the parenchyma of the liver and of the kidneys. Furthermore, they cause some changes in the blood, as a leucocytosis, etc. Work of this kind is valuable, because practical conclusions can be drawn that are of benefit to the surgeon, obstetrician and physician, who have occasion to use these anesthetics.

The Chicago Medical Society met March 25, 1903, with president, Wm. A. Evans, in the Chair. J. L. Miller read a paper entitled **Pneumococcus Septicemia**.

He said that bacteriemia was a more suitable term than septicemia. Whether an infection remains localized or becomes generalized depends largely upon the resistance of the individual, and the virulence of the infectious agent. The diplococcus pneumonia inoculated into a highly susceptible animal, as the mouse and rabbit, does not manifest itself as a localized process, but becomes a bacteriemia. In less susceptible animals,

when inoculation is made directly into the lung, a process resembling pneumonia follows. Pathological findings, animal inoculations and clinical observations indicate that pneumonia is often a septicemia before blood cultures actually demonstrate the organism. Two investigators report positive cultures from the blood in all cases examined; 154 cases collected from other reports show positive results in twenty-four per cent. The earliest positive results were obtained upon the second day of the disease. Blood cultures will be of little diagnostic aid, as the disease is easily recognized from the physical findings. From a prognostic standpoint, it is of value, a bacteriemia indicating a grave infection. Eighty-seven per cent. positive cases died, and only twenty-two per cent. of the negative cases.

Arthur R. Edward's followed a paper on **The Diagnosis of Pneumonia**.

The author said that mistakes are rare in the diagnosis of primary frank pneumonia in adults. They occur mostly in the aged, alcoholics, children, and in pneumonia secondary to cancer, nephritis, diabetes, etc. Therefore, the physician should watch all diseases when the respiration, pulse and temperature rise, or when, even without these or other symptoms, the subject of chronic disease is not doing well. The onset symptoms, the chill in adults, convulsions in children, vomiting in the very young or in adolescents, suggest at least the possible onset of lobar pneumonia. Chill, pain in the side, sudden high fever, and rusty sputum are almost positively final, since pneumonia is practically the only disease where they occur, guarding against the chief diagnostic confusion, infarct of the lung, in which the same symptoms may obtain, although here the sputum is reddish, but is not viscid, and is usually far more abundant than pneumonia.

As to diagnosis from the physical findings in the lungs, these findings are usually detected in the frank case of pneumonia on a thorough thoracic examination, and as a rule appear within two days after the characteristic symptoms of onset. These physical findings were detailed.

The author presented a table differentiating pneumonia from effusive pleurisy.

Pneumonia in children occurs with an abrupt onset without chill (before the seventh year,) but with vomiting or convulsions or other cerebral or meningeal symptoms. Cough is absent since the bronchi are not involved; no sputum appears, and pain from the third to the fifth year, or, indeed, later, and also in adults, is referred to the abdomen, but without tenderness there. Pain is more important than increased respiration, which occurs with any elevation of temperature. Respirations number 80 under two years; in older children 50 or over. Crepitant rales are usually absent because of the superficial breathing caused by pain. Latency of signs is sometimes noted, as no bronchial breathing, no bronchophony, no dullness. Localization is more often central, in the upper lobes or migratory. Lysis is more frequent than in adults. In children pneumonia may be mistaken for abdominal disease, for pleurisy, or brain affections. In alcoholics the dis-

ease is insidious, often without pain, cough or sputum, etc., and the lung symptoms may be overlooked, since the clinical picture of delirium tremens masks the signs of pneumonia.

Pneumonia secondary to tuberculosis, emphysema, arterio-sclerosis, hepatic cirrhosis, nephritis, diabetes, typhoid, influenza, diphtheria, anesthesia by ether, etc., is most frequently overlooked and the greatest care in chronic cases is necessary. Sudden death here and in general is often pneumonic.

Of other variations in the clinical course, the author mentioned the rarer forms, as abortive pneumonia, ephemeral pneumonia, relapsing or recurrent pneumonia. He discussed delayed or imperfect resolution; also local variations; massive pneumonia, etc., and as a final general statement he said that few diseases are recognized as easily as is fibrinous pneumonia, when careful consideration is given to its onset, symptoms, signs and evolution, and when, no symptom of pneumonia presenting, the patients with other disease are carefully, systematically and repeatedly examined.

#### Treatment of Pneumonia.

James B. Herrick referred particularly to certain erroneous practices in the treatment of pneumonia, and argued for a simpler therapy and less free use of drugs. The expectant and symptomatic treatment was, for the present, seeing no specific remedy is known, the only rational one. The physicians can educate the laity to a knowledge of the self-limited nature of pneumonia, and a treatment as scientific as that in typhoid will be possible. He urged that oxygen be allowed to come in through the window, and not given entirely from the tank. No hard and fast rule as to diet should obtain; there should be individualization in this regard. Alcohol was seldom necessary. Hydrotherapy was proper for the reduction of temperature. Salt solution was of value, but its use ought not to be deferred until the patient is in extremis. Morphine was the best remedy to relieve pain and induce sleep, though it should, of course, be used with caution. Local applications were of doubtful value. They should not be so heavy or so light as to embarrass respiration. Bleeding was occasionally of benefit. The giving of many drugs for each trifling symptom was not indicated, and was often harmful. There was danger in the too free use of stimulants.

Edward F. Wells stated that he had collected series of cases from the literature, which have been recorded during the past one hundred years, this table embracing at the present time about four hundred thousand cases, with a mortality rate of twenty-two per cent. or more. He believes the mortality of pneumonia is under-stated rather than over-stated.

In speaking of the diagnosis of pneumonia, mention is frequently made of central pneumonias and the difficulty attending the diagnosis of these forms of the disease. A patient in full health is stricken by disease which prostrates him. He may lack cough and expectoration, still there may be fever, which is usually present. The prostration, the increased respiratory ring, the presence of leucocytosis of a peculiar character, the leucocy-

tosis being due to an increase of polynuclear cells, would make the diagnosis clear to his mind in many cases in which the physician signs are in abeyance. He called attention to one observation which he has made, namely, that in cases of delayed physical signs, in the so-called central pneumonia, when the signs appear, one would find that almost invariably they are a little in front and just below the angle of the scapula. Casts are frequently found in the urine in pneumonia. Granular casts of pneumonia are frequently uniform in size. He believes patients are usually fed too much in pneumonia. Pain in pneumonia declines in about three days, or subsides, regardless of what is done to relieve it.

E. Fletcher Ingals said the importance of not cutting off air is a point that should be impressed upon all physicians in treating pneumonia. Pneumonic patients should not be fed in a routine manner. The proper administration of food is often neglected, and physicians frequently overlook the matter of feeding of the patient. He agrees with the essayist that opiates must be given if pain cannot be relieved in some other way. Ordinarily, he believes bromide of ammonium will relieve insomnia if the drug is given early enough.

Walter M. Fitch asked whether the antitoxin of pneumonia was of any value. Also, whether nuclein preparations are of any value in pneumonia other than producing a leucocytosis.

Edward H. Ochsner spoke of systematic strapping of the affected side in cases of pneumonia. In the great majority of patients, who are thoroughly strapped early in the disease, the pneumonia disappears by lysis and not by crisis. His explanation is that the intoxication is not so sudden and severe, and it gives the patient a chance to produce immunity before he is completely intoxicated so as to cause death. He demonstrated the method of strapping these patients.

M. Herzog stated that pneumococcus septicemia is difficult to diagnose, but that this difficulty is largely done away with if a blood examination is made early, and attempts made to obtain pure cultures of the pneumococcus in the blood.

B. W. Sippy stated that in those cases that have the normal number of leucocytes, or less than the normal number of leucocytes, they were more likely to run a serious course. He mentioned the case of a boy with double lobar pneumonia, the first count showing six thousand leucocytes. The case ran a mild course, and at no time was the number of leucocytes higher than eight thousand.

The discussion was closed by the essayists.

New members of the Chicago Medical Society:

Bachelle, C. V., 100 State st.  
 Cochems, P. N., Salida, Colorado.  
 Chapman, Chauncey F., 940 W. Madison st.  
 Eastlake, Lewis S., 4707 Evans ave.  
 Fowler, J. V., 312 Grand ave.  
 Grosvenor, Lorenzo N., 915-34 Washington st.  
 Rogers, Cassius C., 70 State st.  
 Seville, Frederick, 1573 W. Monroe st.



Stevens, Charles A., 59th and Morgan sts.  
 Stolp, Byron C., Wilmette, Ill.  
 Strawn, Julia C., 827 Marshall Field Bldg.  
 Walsh, J. H., 480 Grand ave.  
 Wylie, J. S. Matherson, 1308 Masonic Temple.  
 Young, C. C., 4216 Berkley ave.  
 Young, N. A., 4216 Berkley ave.

**Northwest Branch.**—A meeting of the members of the Chicago Medical Society residing in the district between Chicago avenue and Graceland avenue and west of the river, extending to the county line, was held March 6, 1903, at Schoenhoffen Hall for the purpose of organizing a branch society in this district.

The following officers were elected: M. H. Luken, president; Karl F. M. Sandberg, vice-president; L. Feingold, secretary; C. F. Roan, treasurer; committee on program, Drs. Sandberg, Feingold and E. C. Seufert.

The Secretary was instructed to secure a permanent place for meeting, and the first Friday of each month was selected as the day of meeting.

Due notice of announcements will be made by the Secretary.

L. Feingold, Official Reporter.

**The Southern District.**—Notice of Meeting and Election.—A meeting of the Southern District of the Chicago Medical Society was held at "The Vincennes," 36th street and Vincennes avenue, Thursday evening, March 19th, at 8:30 o'clock.

C. S. Suker demonstrated a number of interesting pathologic conditions of the retina.

Milton H. Mack read a paper on *Gastrectasia*."

A councilor to represent this branch in the council of the Chicago Medical Society was elected at this meeting.

W. S. Harpole, Official Reporter.

**The North Shore Medical Society** held the regular monthly meeting in Bennett Hall, Tuesday evening, March 3, 1903, at 8:30. Meeting called to order by Chairman Herzog. Minutes of adjourned February meeting read and approved. The following program was rendered:

**Symposium on Influenza**—1. Etiology and Bacteriology, R. C. Whitman.

2. Symptoms and Types, Wm. Healy.

3. Complications, G. W. Green.

4. Diagnosis Prognosis and Treatment, Bertha Bush.

Dr. Bush was unable to be present and Dr. Young responded to request of chairman to say something on that part of the subject.

Discussion was opened by Dr. Herzog and continued by Drs. Houston, Snyderacker, Whitman, Baxter, Green. Dr. Whitman reported case of tuberculosis and exhibited a slide with the tubercle bacilli. The following business was ordered. The executive committee was empowered to consider and choose a suitable place of meeting and announce in weekly bulletin.

Call for report on committee on Organization report deferred until next meeting. Motion empowering chair to appoint a committee to

draft constitution and by-laws in accordance with plan as suggested in newly adopted constitution of the Chicago Medical Society. Carried. Committee appointed Drs. Healy, Green and Baxter. Society adjourned.

George Edwin Baxter,  
 Official Reporter.

**The Chicago Pediatric Society** held a joint meeting with the Chicago Medical Society in Schiller Hall, Wednesday evening, March 11, to listen to an address by Thomas M. Rotch, professor of Pediatrics in Harvard Medical school. His subject was *the Study of Pediatrics in its Relation to Medical Education*. He gave a brief outline of his methods of teaching pediatrics and emphasized very strongly the importance of having a better and longer course in this branch of medicine in our medical schools. Every one appreciated the privilege of seeing and hearing this great worker in pediatrics. A unanimous vote of thanks was accorded him by the societies for his very interesting paper.

J. M. Dodson announced a meeting for March 22d, in the Art Institute for the purpose of discussing the question of *child labor*. Rev. Dr. Hirsch and Miss Jane Adams will be among the speakers.

Preceding the evening meeting a dinner was given by our Society in honor of Dr. Rotch.

Emma M. Moore, Official Reporter.

#### Chicago Gynecological Society.

A joint meeting of this Society was held with the Chicago Medical Society, March 18, 1903, with Charles S. Bacon, the President of the former Society, in the chair.

Charles S. Bacon contributed a paper entitled *Definition of Accouchment Force and the Indications*.

Among other things, he stated that the term accouchment force is an imported one, and is applied to various methods of removing forcibly from the gravid uterus its contents when the cervix is closed or only partially dilated. It embraces two procedures, dilatation of the cervix, and the extraction of the contents of the uterus. Dilatation of the cervix may be accomplished in different ways. These ways were discussed at length.

He briefly described a few of the principal obstetrical complications which call for the use of one or the other of the methods of forced delivery. Eclampsia is undoubtedly an obstetric complication in which most often accouchment force is used. If the cervix is dilated at the beginning of the eclamptic attack, the uterus should be emptied. But when the cervix is closed, there is still diversity of opinion as to the procedure that should be adopted. Formerly, accouchment force gave such bad results that it was generally condemned in the treatment of eclampsia, but within the last ten years it has come to be generally used. Other serious conditions of the mother which may demand forced delivery are severe anemia, weakness due to other organic diseases, as tuberculosis and heart disease. Antepartum hemorrhage is another condition which demands forced rapid delivery.



That variety of antepartum hemorrhage due to premature detachment of the normally-seated placenta gives perhaps the most urgent indications for accouchement force. Those who have had experience in vaginal surgery would probably prefer in these cases not only the incision of Dührssen, but the extension of that incision through into the lower uterine segment, making what is now described as the vaginal Cesarean section.

Accouchement force in placenta previa, he said, has been used probably ever since this complication was known, and it is still used, too often improperly, owing to the conditions that are frequently present in placenta previa.

**Bag and Hand Dilatation.** This subject was discussed by Robert L. Dickinson, of Brooklyn, New York, by invitation. He said that accouchement force is major surgery. These operations belong in the hospital operating room, as the grave conditions of eclampsia and placenta previa may be foretold. Barnes' bags are anatomic errors. The conical balloon of Champetier dried and broke apart on slight traction, while the undue elongation of the cone showed the presenting part up out of the brim and permitted the cord to prolapse. The simple, strong, short cone of Voorhees, inelastic, thin enough to slip in, when rolled, wherever the finger tip will pass, with no stopcock to get out of order, is durable, efficient and inexpensive.

For rapid dilatation, the tube is pulled upon steadily or with intermissions; but if the normal process is to be simulated or expedited, the douche-bag is raised and lowered, and contractions produced, or lessened, literally, turned on or off, as desired.

The disadvantages of dilatation by these methods are the same that apply to all artificial methods of opening the cervix. Although the lips of the cervix are opened and separated thereby, thinning, retraction and effacement do not occur. At least, the normal disappearance of the cervix does not occur, unless the uterus is induced to take an active part. But the advantages of the balloon call for frequent use. The procedure more nearly resembles the normal process than any other method of artificial dilatation. It inflicts less injury than any other. The outfit is light, inexpensive, and compact, and its use is within the range of the general practitioner. Its field is not small, for although its action is usually less rapid, like that of branches dilators or the hand, and though the most rigid conditions may not yield to it, yet it has no rival at all for induction of labor, for inertia in the first stage, and as a tampon dilator in placenta previa with a thick, unyielding os.

There is nothing so intelligent as the finger, nothing less dreaded, nothing so handy. It will always be the main resource, and this whether it is asked to initiate labor by stripping the membranes or to stretch fully the cervix. Put the rubber cover on it and it is sterile. Give the hand time, and few cases can resist its action.

The disadvantages of manual dilatation are: (1) Infection, overcome by the rubber glove. (2) Laceration, overcome by patient gentle-

ness. (3) The swollen, contused and unthinned result, a drawback common to all artificial methods. (4) The difficulty in reaching or entering the internal os when the cervix stands far back in the pelvis, and is not to be coaxed within touch of the finger tip. This trouble is easily overcome by the single tenaculum gently drawing downward on the anterior lip. And, lastly, there are occasional rings so rigid that no finger can pass them. For them, the knife or metal dilator is demanded. These in hospital work, we fearlessly cut wider, then deliver, and repair.

In the choice of the method of extraction, the American will often prefer the forceps where the German would bring down the foot. Whenever speed is the main consideration, one is obliged to turn. Whenever, in placenta previa, the head cannot be made to blockade the cervix, one must turn. This version is our chief reliance; but its indiscriminate employment must be limited because of the danger of shock, sepsis, rupture. One may not in-advise add shock to shock, in blood loss, or eclampsia. For induction in the latter months, and for inertia during labor, where other causes are eliminated, such as exhaustion, overdistention and malposition of passage or passenger, the bag comes first, then the hand, and the forceps finishes their work. In placenta previa the balloon should be used for the narrow cervix that bleeds, when the head will not plug it; version for the bad cases, since the thigh is the surest tampon. For brisk hemorrhage of detachment of a normally located placenta, the greatest speed is attained by manual or metal dilatation. For the rigid cervix of the early months, for the unyielding girdle of the elderly primipara, for the gristly hardness of eclampsia, the powerful Bossi instrument is a great boon, and none of its imitators approach it.

#### Abdominal and Vaginal Cesarean Section as a Means of Accomplishing Accouchement Force.

J. Clarence Webster presented a paper on this subject. He stated that abdominal and vaginal Cesarean section are rarely necessary as means of rapid delivery. The latter procedure has been employed by very few operators. It is mainly due to Dührssen's advocacy, in 1896, that it has begun to attract notice. The technique of the operation was described in detail.

The essayist next considered abdominal and vaginal Cesarean section in relation to the various conditions in which accouchement force is most commonly employed.

In rare cases of eclampsia, it may be indicated, namely, in contractions of the birth canal by pathological changes in the soft or hard parts which make delivery through it impossible. When also an eclamptic dies, the fetus being alive in utero, it is the duty of a physician, who may be present at the time of death, to advise immediate post-mortem Cesarean section. Bauer has recently reported eight such cases, in which four infants were saved. Vaginal Cesarean section is to be recommended in cases of eclampsia in pregnancy or in early labor in which the cervix is rigid and difficult to dilate.

Within the last few years, abdominal Cesarean section has been performed in several cases of placenta previa. This procedure has been widely criticized. If women were always in hospitals, where the operation could be done promptly by an expert operator immediately after the diagnosis was made, the essayist thinks the results might be more satisfactory, both to mother and infant, than those obtained by all other methods of treating placenta previa, but under the conditions which exist in ordinary private practice, the results would undoubtedly be worse.

Although several obstetricians have suggested abdominal Cesarean section in certain cases of premature detachment of the normally situated placenta, it has been rarely employed. The operation, in the opinion of the essayist, should only be considered when it is impossible to carry out other procedures by the vaginal route. Vaginal Cesarean section is indicated in cases of accidental hemorrhage where the patient's condition is critical, and where the cervix cannot be rapidly dilated by the ordinary methods, providing a competent operator is at hand. In affections of the heart, lungs, kidneys, etc., where the mother is in danger, and rapid delivery indicated, this operation may be undertaken. In these various conditions, vaginal section is indicated where the cervix does not admit of easy dilatation. The abdominal operation should not be employed, save where there is no possibility of satisfactorily performing vaginal section.

#### Rudolph W. Holmes discussed **Cervical Incisions in Labor.**

The author said that the use of cervical incisions is by no means a new obstetric procedure, as for a century or more cutting operations upon unyielding cervixes have been fully recognized.

He discussed the anatomical considerations, indications, essential indications, atresia of pregnancy, rigidity without closure of os, ventro-fixation, contributory indications, premature rupture of membranes, generally contracted pelvis, eclampsia, heart disease, contra-indications, dangers, the operation and technique.

In closing, he expressed his strong condemnation of the too common practice of using forceps through the partially dilated os. He believes that forceps never were intended for dilators. If an instrumental delivery is indicated and full dilatation is not present, some method of dilating the os must be used first. A great advance in the progress of general obstetric practice will be realized when the profession learns that partially dilated os is a positive contra-indication to the use of forceps. Dr. Holmes concludes:

1. The contributions of Dührssen to the subject of cervical incisions are not sufficiently original to warrant a proprietary right in the nomenclature. Coutouly, Baudelocque, Bedford, Braun and Skutsch did much to develop our knowledge of the subject.

2. Effacement of the cervix is an indispensable prerequisite to the use of incisions. For this reason incisions are especially applica-

ble to primiparae, and are often contraindicated in multiparae.

3. Incisions are indisputably of value, even necessary in essential indications. In contributory indications their use is a mooted question. The judgment of the operator must decide in individual cases.

4. Manual dilatation preliminary to incisions does not secure the best cervical condition for incisions.

5. Incisions always are potentially dangerous; dangers comprise infection, hemorrhage, and extensive lacerations beyond the vaginal vault.

6. Use of incisions demands an obstetric armamentarium, assistants, and a definite experience in obstetric procedures.

7. The details of the technique may be modified to suit the taste of the operator.

8. The minimum number of incisions to meet the exigencies of the case should be made.

9. Oblique incisions may be proven to be more advantageous as regards the after-effects than the usual quadrant cuts.

10. In the absence of hemorrhage, or accessory lacerations, it is a mooted question whether the incisions should be sewed up or not.

11. Immediate delivery should follow the incisions.

Joseph B. DeLee spoke of the **Bossi Dilator and its Place in Accouchement Force.**

The inventor of this instrument had used it since 1890, and had shown it at several medical congresses, but few obstetricians had used it until recently. The dilator has been used with success recently in Dresden, Prague, Berlin, Paris, and several other foreign cities. Its use in this country has not been published, although the author finds that it has been employed at John Hopkins and at the Sloane Maternity, New York. The essayist has used the Bossi dilator three times.

Dührssen has made an exhaustive study of most of the reported cases, and concludes that the Bossi dilator is a dangerous, inefficient, and useless instrument. The literature on the subject is rapidly increasing. The author's own opinion, based on three cases which he reported in detail, and a study of the many reported cases, is as follows:

1. There is a small field of usefulness for the instrument in cases where rapid dilatation of the cervix is necessary after effacement. Before effacement, the colpeurynter should be used. It will be more successful in multiparae.

2. The instrument will be useful in dilating the cervix in those cases where manual dilatation would be successful. It possesses advantage over the hand in the asepsis, in that it is not so tiring, so that the operator may carry out the subsequent delivery comfortably.

3. The instrument is not safe, but requires careful and skilled watchfulness, and one must search for and be ready to repair more or less extensive lacerations. These are greater in primiparae.

4. It should never be used in placenta previa.

5. It does not replace the colpeurynter, the use of the hand, or cervix incisions in all cases.



The Calhoun County Medical Society met in Hardin, at Flatt's drug store, March 16, 1903. Roads were bad and attendance small. Some of our members have twenty-five miles to attend the society. The meeting was called to order by P. C. Barry, President.

The time was spent in reporting bad cases and their treatment. It was also decided to adopt the plan of organization suggested by the State Society. The following members paid the two dollars: W. A. Skul, J. R. Vaughn, S. Flatt, Dr. McCauley, T. O. Hardesty, to the secretary to remit. Dr. Hardesty reported smallpox in Kampsville. The Society approved the proposed medical legislation. Drs. McCauley and Hardesty contemplate attending the meeting of the American Medical Association at New Orleans.

T. O. Hardesty, Official Reporter.

#### PROGRAM, TITLES AND ABSTRACTS OF PAPERS FOR THE 53d ANNUAL MEETING OF THE ILLINOIS STATE MEDICAL SOCIETY.

The next meeting of the Illinois Medical Society will be held in Tremont Temple, Dearborn and Lake sts., Chicago, April 29 and 30, and May 1 and 2.

Within the next two weeks a program will be mailed to every physician in the State. Details will be explicitly given and each member is asked to keep this and bring it with him to Chicago. This statement is provisional, and is to be accepted as such.

There were two reasons for selecting the date above given. The first was, we wanted to send our representatives to New Orleans from a State, with a banner organization. This will require some changes in our Constitution and By-Laws, and co-operation on the part of the county societies. Incidentally, we hope that the county societies will act upon the recommendations of President Harris before the State meeting.

The second reason was that such a time would make it very convenient for the members to attend the State meeting and then go to New Orleans. The two trips need not keep a man from home over ten or eleven days.

A Committee on Clinics has been appointed, and these gentlemen have arranged a schedule beginning on April 22. Free admission is offered to one or more clinics during every hour of every day, except Sunday. These clinics will cover every branch of medicine. In addition, a full program of clinics has been arranged for each day of the meeting. It has been agreed by the clinicians of Chicago that no clinics will be given during the hours when the Society is in session. During each hour set aside for clinics, the visitors can choose from several opportunities.

The programs of Section work are fully up to standard. To hear and discuss the papers

in the Sections will certainly be worth attendance on the meeting.

The program places the work of the Business Section, known as the House of Delegates, in the afternoon, and all members of the Society are invited to attend the meetings of this body. Participation in its deliberations is limited to the duly accredited delegates.

The preliminary meeting which has usually preceded the regular meeting, will not take place this year. This meeting grew out of the inadequacy of the old method of organization to do any business in a deliberative fashion. It is expected that the House of Delegates will supply this deficiency.

It will be noticed that the general session on Wednesday morning is nominal. This is done to fulfill the technical requirements. Really it is proposed to give over the forenoons to Section work. In the afternoon the members can select a program of clinics, visit the House of Delegates, chat with friends in the parlors, visit the scientific exhibit, or renew acquaintance with our friends with things to show, explain, demonstrate, or sell.

The open parlor we hope will prove an acceptable innovation. The scientific exhibit is also an innovation; we hope that this will prove an attraction. Members who have specimens with which they intend to illustrate papers, are asked to leave them in the exhibit except when in use in connection with their papers. Other members having specimens of interest, are asked to place them in the exhibit.

The commercial exhibits are on the 5th floor. No elevators go beyond this floor. Our members can always spend some portion of their time to advantage, in these exhibits.

At the evening general session, we propose to have some addresses by prominent men of the city, after which we will listen to the President's address, and attend to such other business as belongs to the mass meeting. Placing this meeting in the evening is an innovation that we think will appeal to those who have witnessed the usual struggling character of opening sessions.

Thursday evening is left open so that those in attendance can do as they please or go where they please. The lady physicians of Chicago have planned a reception for the visiting lady physicians, on this evening. Other entertainments, somewhat less formal, will be in order.

The Friday evening program has not yet been decided on. We feel quite certain that there will be no formal banquet. There will probably be some stage entertainment followed by a buffet lunch—probably "smoker" would more nearly describe what we now have in mind than would any other term.



The registration office, hotel and boarding house directory, and post office will be at the old hotel desk in the lobby.

It will be remembered that the building is the old Tremont Hotel. The amphitheatres and clinic rooms are those that have been built in by Northwestern University for its Dental School. The Clinic Room will seat approximately twelve hundred people. The three amphitheatres are on the same floor (the sixth). They will seat from two hundred to four hundred people each.

The building is very centrally located. Every elevated road passes by the door, and has a station just one block away. Every cable system reaches within two blocks. The out-of-town visitors can come on the cars, street or elevated, right to the hall, and find there a list of hotels and boarding houses. The Sherman House is located just across the street. In case he wishes to get farther away, the suburban hotels such as the Lexington, are reached by adjacent car lines.

On Sunday, special trains will leave Chicago for the New Orleans meeting. These trains will provide some time for visiting New Orleans and the neighboring towns, by those who wish. Those who wish to attend such meetings as that of the American College Association, will be in time for them.

The regular trains leaving here up to Sunday evening, arrive in New Orleans in time for the meeting.

The fare will be one and one-third. Members are reminded that in purchasing tickets, they must take a certificate of purchase from the local agent. This must be indorsed by the railroad agent in the registration office, at the meeting.

#### PROVISIONAL PROGRAM.

Place of Meeting, Tremont Temple, Lake and Dearborn Sts., Chicago. Time: April 29 and 30, and May 1 and 2.

#### Wednesday, April 29—First Day.

8:00 A. M. Registration office, Lobby, first floor, open.

9:30 A. M. General Session called to order in Clinic Room, 6th floor.

9:45 A. M. Adjournment of General Session until 8:00 P. M. Same hall.

10:00 A. M. Section I. called to order, Amphitheatre, 6th floor.

10:00 A. M. Section II. called to order, Amphitheatre 2.

10:00 A. M. Section III. called to order. Amphitheatre 3.

10:00 A. M. Parlors open, 2d floor.

10:00 A. M. Exhibits open, 5th floor.

10:00 A. M. Scientific Exhibit open, 5th floor.

1:00 P. M. Adjournment of all Sections.

2:30 P. M. Registration in Lobby.

2:30 P. M. House of Delegates, Clinic Room, 6th floor.

2:30 P. M. Clinics in various Hospitals and Colleges.

2:30 P. M. Parlors open.

Scientific Exhibit open.

Exhibits open.

8:00 P. M. General Session.

Welcoming Speeches.

Address of President Harris.

#### Thursday, April 30—Second Day.

8:00 A. M. Registration in Lobby.

All Exhibits open.

Parlors open.

9:00 A. M. Section I, Regular order, place noted above.

9:00 A. M. Section II, Regular order, place noted above.

9:00 A. M. Section III, Regular order, place noted above. Completion of work of this section.

1:00 P. M. Adjournment of Sections 1, II and III.

2:30 P. M. House of Delegates, Clinic Room.

2:30 P. M. Clinics all over town.

2:30 P. M. Parlors open.

Exhibits open.

Scientific Exhibit open.

8:00 P. M. No work.

#### Friday, May 1—Third Day.

8:00 A. M. Registration Office open.

9:30 A. M. Parlors open.

Scientific Exhibit open.

Exhibits open.

10:00 A. M. Section I. Regular order.

10:00 A. M. Section II. Regular order.

1:00 P. M. Adjournment.

2:30 P. M. House of Delegates, Clinic Room.

2:30 P. M. Clinics all over town.

2:30 P. M. Parlors open.

Scientific Exhibit open.

Exhibits open.

8:00 P. M. Entertainment in the Clinic Room.

#### Saturday, May 2—Fourth Day.

8:00 A. M. Registration Office open.

9:30 A. M. Parlors open.

Exhibits open.

Scientific Exhibit open.

10:00 A. M. Section I. Regular order.

10:00 A. M. Section II. Regular order.

1:00 P. M. Adjournment of Sections.

2:30 P. M. Clinics all over town.

2:30 P. M. Parlors open.

Scientific Exhibit open.

Exhibits open.

Adjournment.

Sunday, May 3 and Monday, May 4, leave for New Orleans.

#### SECTION ONE.

1. "The Dangers of Exclusive Milk Diet in Nephritis." A. C. Crofton, 100 State st.

##### Abstract.

The popular prejudice in favor of an exclusive milk diet in nephritis and the fundamental fallacies of this prejudice; the three indications for dietetic treatment of nephritis: (1) Protection of the secreting epithelium of the kidney; (2) protection of the cardio-vascular apparatus; (3) protection of the general nutrition of the patient. Reasons why an exclusive milk diet

meets none of these requirements. The best substitute for an exclusive milk diet, as deducted from modern investigations into the causes of nephritis and the excretion of urinary solids in inflammatory diseases of the kidneys.

2. "Pulmonary Tuberculosis and its Home Treatment." James L. Lowrie, Lincoln.  
Abstract not in.

3. "Cockroaches as Typhoid Infection Carriers." Rosa Engelmann, 100 State st., Chicago.

**Abstract.**

(1) Vermin as active intermediary hosts of various infections; (2) history of a house epidemic of typhoid fever; (3) Cockroaches; sewage and water denizens not heretofore classed as typhoid infection carriers; (4) need of examination and cultures from intestinal contents and from feet of cockroaches for pathogenic germs—especially the Eberth bacillus; (5) opportunity the coming summer (after necessarily prolonged rainfall) for such work in the vermin-infested slums of Chicago.

4. (Title not in.) E. A. Edlen, Moline.
5. "Xanthome (or Brometone), a New Sedative; Its Therapeutic Effects in Relieving the Cough and Headache of Acute Tracheitis and in Relief of Asthma." E. Fletcher Ingals, 34 Washington st., Chicago.
6. "Lacunar Tonsillitis." James Moreau Brown, 34 Washington st., Chicago.
7. "Alimentary Putrefaction." J. W. Hensley, Peoria.
8. "The Distribution of Blood Vessels in the Labyrinth of the Ear, with Exhibition of Preparations and Drawings." George E. Shambaugh, 100 State st., Chicago.

**Abstract.**

This subject has been worked out by making a large center of celloidin carts of the pig's ear from preparations in which the blood vessels had been previously injected. Such celloidin carts when cleared in creosote become perfectly transparent, and when viewed with the stercoscopic microscope, present a beautiful picture of the circulation in its entirety. Specimens and drawings will be exhibited.

9. "A Few Cases of Hysteria." H. T. Patrick, 34 Washington st., Chicago.

**Abstract.**

A report of cases of hysterical paraplegia, hysterical amblyopia with rigid pupil, hysterical anorexia, hysterical pseudo meningitis and hysterical deaf mutism.

10. "Interstitial Nephritis; Its Diagnosis and Management." Edward F. Wells, 47th and Kenwood ave., Chicago.
11. "Pneumonia as an etiological factor in Nervous Diseases." Frank P. Norbury, Jacksonville.

12. (Title not in.) Charles Louis Mix, 3035 S. Park ave., Chicago.
13. "The Diagnosis and Treatment of Obscure Syphilitic Lesions of the Eye." E. F. Snyder, 103 State st., Chicago.

**Abstract.**

Frequency of blindness due to syphilis; frequency with which syphilis simulates various eye diseases; history of a number of such cases; impossibility of diagnosis of such cases from clinical aspect alone; co-existence of syphilis with other diseases; necessity of careful urinalysis in lesions of the eye even though syphilis is known to be present; value of therapeutic test in all suspicious cases; therapeutic methods.

14. "The Insane Temperament." Sanger Brown, 100 State st., Chicago.
15. "The Therapeutics of Suppurating Ear Diseases in Relation to the Bacteriological Findings." Ralph C. Matheny, Galesburg.
16. "The Presence of Seminal Elements in the Urine; Their Significance and their Importance as a Cause of False Albuminuria." Arthur R. Elliott, 103 State st., Chicago.

**Abstract.**

Frequency and clinical importance; entire lack of literature on the subject; physiologic and pathologic conditions under which semen gains access to the urine; chemical re-actions produced by seminal elements in the urine; microscopic characteristics; relation of cases; differential testing.

17. "The Treatment of Some of the Degenerations of the Cerebrospinal Apparatus, with Particular Reference to Optic Atrophy." Archibald Church, Pullman Building, Chicago.

**Abstract.**

The general feeling is that degenerations taking place in the conducting tracts of the cord, as in locomotor ataxia, and atrophy of the optic nerve, arising from any cause, as well as the changes in the brain and cord that are found in parietic dementia are quite unamenable to treatment. In all of these conditions the tendency to remission is in itself a confusing element in judging the therapeutic value of any line of treatment.

In the case of the optic nerve the ophthalmoscope enables us to actually see changes which are taking place and by appropriate tests, variations for better or worse can be actively determined and systematically recorded.

A number of cases of optic atrophy associated with a secondary syphilis have been under observation for from two to ten years and are made the basis of an estimate of the value of mercury in controlling these degenerations.

Ophthalmoscopic examinations and perimetric records made in these cases by competent oculists, demonstrate that in some instances degenerations in the optic nerve can be distinctly controlled. Other cases of locomotor ataxia and parietic dementia are adduced, in which the clinical records indicate a similar retarding in-

fluence upon the processes of degeneration in brain and cord.

18. "Euphthalmin as a Mydriatic for the General Practitioner." Albert B. Hale, 103 State st., Chicago.

**Abstract.**

The use of the ophthalmoscope is becoming more general in medical diagnosis; need of a drug to dilate the pupil not only to study the condition of the fundus and also to note condition of cornea, iris, and lens. Atropin too powerful and destroys accomodation; Homatropin is of only less strength and is expensive; Cocain good, but dangerous to eye: Euphthalmin scarcely affects accomodation, dilates pupil fully and in a short time; has no dangerous element about it and its effect passes quickly away. Reports of experiments.

19. "Barrow's Method of Formalin Intravenous Injections." J. H. Stealy, Freeport.

20. "Original Researches Regarding Human Sweat." Julius H. Hoelscher, 34 Washington st., Chicago.

**Abstract.**

Over 100 specimens; practical deductions; acenamid loses its antipyretic effect when used in connection with the hot air bath, etc. Diaphoretics should always be used in connection with the hot air bath; sodium salicylate, pilocarpine and acetanilid apparently less toxic when used in connection with hot air baths, etc.

21. (Title not in.) Charles A. Elliott, 70 State st., Chicago.

22. "The Danger that may Lurk in Blind Eyes." Cassius D. Westcott, 31 Washington st., Chicago.

**Abstract.**

Difference of opinion and practice in regard to retention of single blind eyes. Danger of retaining blind, but apparently quiet eyes destroyed by injury and inflammation. Illustrative cases. Danger from malignant disease in some single blind eyes, where accurate and positive diagnosis is impossible. Illustrative cases. Conclusions.

23. "In Which Disease may we Expect Improvement of Hearing." J. Holinger, 103 Randolph st., Chicago.

**Abstract.**

Improvement in hearing.

Introduction: Comparison of methods for comparing the hearing.

Improvement of hearing in acute diseases.

- (a) Simple inflammation.
- (b) Suppurations from the middle ear.
- (c) Mastoid operations.

Improvement in hearing in chronic diseases.

- (a) Chronic suppurations.
- (b) Residues.
- (c) Operations for cholesteatoma.

Chronic progressive deafness.

Differential diagnosis.

1. Affections of the tubes.
2. Spongifying.

24. "Tonsillar Hemorrhage Following Operation." Lawrence R. Ryan, Galesburg.

**Abstract.**

The comparative infrequency of alarming hemorrhage from the tonsils following amputation or complete removal, seems to have dulled the senses of the profession (not excluding our best authors), to the possibilities of its dangers. It is an old saying that "the unexpected always happens," and this is as true in medicine as anywhere else. The young physician who has never had a case of post partum hemorrhage, sympathetic ophthalmia, or grave tonsillar hemorrhage, is apt to assume that such are impossible.

In my first twelve or fifteen years of practice I never had a case of alarming hemorrhage from the amputated tonsil, but within the past year, four cases have come to my knowledge—one of my own, and three from other practitioners.

Since such an occurrence is a possibility, how shall we guard against it? And if it occurs, how shall we treat it? The condition of the patient must be inquired into. Is he a bleeder? Is the hypertrophied tonsil densely fibrous? Are there malignant growths attached? What influence have general anesthesia, adrenalin, or cocain in the possibility of hemorrhage? What form of tonsillatome is the best? Comparative merits of the hot or cold snare and the usual cutting instruments, etc. Report of four cases—two male and two female; the two males hemophiliacs, etc. The treatment used to control hemorrhage.

25. "Report of Cases of Typhoid Fever for the Year 1902, at Cook County Hospital." Arthur E. Price, 538 W. Adams st., Chicago.

26. "Abdominal Pains in Pleurisy and Pneumonia." James B. Herrick, 103 State st., Chicago.

**Abstract.**

Pain in pleurisy and pneumonia may be referred not only to the affected side of the chest, but to the opposite side of the abdomen. In the latter case abdominal disease, e. g., appendicitis, may be simulated. Importance of recognizing the thoracic organ of the pain, as it may thus prevent surgical interference. Illustrative cases. Anatomical basis for the referred pain found chiefly in the course and distribution of the intercostal nerves. Diagnosis generally easy when once the possibility of thoracic cause for the abdominal pain is thought of, and a careful examination of the chest made.

27. "Tabes and Spurious Tabes." D'Orsay Hecht, 4304 Grand blvd., Chicago.

**Abstract.**

1. By way of introduction. (a) Consideration of the term spurious, as here applied; (b) The term pseudo-tabes, a misnomer.

2. Citation of cases with differential considerations.

3. Symptoms, subjective and objective, of genuine tabes in the order of their importance and frequency.

4. Brief therapeutic suggestions.



28. "Unclean Milk; Bovine Tuberculosis and the Tuberculin Test; Their Relation to the Public Health." E. R. Larned, Chicago.
29. "Retinal Hemorrhage in Relation to Degenerations of the Circulatory Apparatus." T. A. Woodruff, 103 Adams st., Chicago.
30. "The Stomach and Intestines in Pulmonary Tuberculosis." Milton H. Mack, 5801 Calumet ave., Chicago.
31. "The Breast vs. The Bottle in Infant Feeding." Alfred C. Cotton, 1485 Jackson blvd., Chicago.
32. "A System of Home Treatment for Chronic Diseases." I. Hirschfeld, Winnetka.
33. "The Use of Intravenous Normal Salt Solution." D. W. Aldrich, Galesburg.

## SECTION TWO.

W. E. Schroder, Chairman.....Chicago, Ill.  
J. B. DeLee, Secretary.....Chicago, Ill.

## Surgery and the Surgical Specialties.

Address:

"The Renaissance"

J. L. Wiggins, East St. Louis.

1. "The General Practitioner and his Relation to Early Surgical Operations." E. B. Montgomery, Quincy.
2. "Spinal Injuries." E. Mammen, Bloomington.
3. "The Traction Injury of Arteries." S. M. Wylie, Paxton.
4. "Modern Surgery of Congenital Cleft Palate." S. R. Hopkins, Springfield.

## Abstract.

History and evolution of the operation.

Description of uranoplastic operation in infancy and its advantages over later operations, with statistics of different operators.

Description of staphylorrhaphy in later life.

Remarks on the power of speech following operations.

Recommendation of a change from the usual *modus operandi* of closing continuous clefts in children over six months of age, with a report of two cases illustrating the proposed method.

5. "Insanity following Surgical Operations." W. H. Maley, Galesburg.
6. "A Singular Dislocation of the Metacarpophalangeal Joint, Irreducible under Anesthesia." Homer M. Thomas, Chicago.
7. "Successful Removal of a Cystic Fibromyoma of the Uterus, weighing Eighty-seven pounds." J. Clarence Webster, Chicago.

8. "Continued Development of the Fetus after Rupture of the Membranes and Prolapse of the Cord." H. W. Chapman, White Hall.
9. "The Indications for the Tampon in Post Partum Hemorrhage." C. S. Bacon, Chicago.
10. Operative Dysmenorrhea." G. Kolischer, Chicago.
11. Title Unannounced. Emil Ries, Chicago.
12. "The Treatment and the Causes of Death in Placenta Previa." P. M. Burke, La Salle.
13. "Ovarian Dysmenorrhea, its Treatment by a New Method of Operating." Norman Kerr, Chicago.
14. "Pelvic Abscess." J. A. Baughman, Neoga.
15. "The Curette in Puerperal and Non-puerperal Cases." W. P. Davidson, Sullivan.
16. "Tuberculosis of the Vestibule of the Female Genitals." J. H. Stealy, Freeport.
17. "Radio-Therapy, with Report of Some Cases." Chas. D. Center, Quincy.
18. "Clinical Report of Two Tumors Benefited by the X Ray." W. J. Eddy, Shelbyville.
19. "Vibratory Massage in Diseases of the Prostate Gland." L. E. Schmidt, Chicago.
20. "Indications and Limitations and Technic of Prostatectomy." G. F. Lydston, Chicago.
21. "Pemphigus." E. A. Fischkin, Chicago.
22. Title Unannounced. E. A. Edlen, Moline.
23. Title Unannounced. Jos. B. Bacon, Macomb.
24. "The Treatment of Injuries of the Eye." Henry Gradle, Chicago.
25. "Accidents of the Antrum, with Special Reference to a Peculiar Case." E. V. D. Morris, Galesburg.
26. "The Surgical Treatment of Trachoma, with Report of Cases and Demonstration of Method." J. Whitfield Smith, Bloomington.
27. "The Treatment of Peri-tonsillar Abscess." Norval H. Pierce, Chicago.
28. "The Management of Crossed Eyes in Children." Willis O. Nance, Chicago.
29. "Dislocation of the Astragalus; Its Surgical Treatment." J. F. Percy, Galesburg.

30. "Hypertrophic Rhinitis." Charles M. Robertson, Chicago.
31. "Strangulated Hernia: A case which required the resection of seven inches of gut, exsection of the appendix, right tube and ovary and the evacuation of a large abscess." Carl E. Black, Jacksonville.
32. "Practical Comments on the diagnosis and Treatment of Pelvic Suppuration in Women." F. Henrotin, Chicago.

### SECTION THREE.

W. K. Newcomb, Chairman.....Champaign  
W. C. Bowers, Secretary.....Decatur

Address—"Food, by J. A. Wesener, Chicago.

#### Abstract.

Definition.  
Digestion.  
Assimilation and caloric value.  
Flavors.  
Adulteration.  
Diet for all classes, and adapted to climate.  
What role does food play on the temperament of the individual?

1. "Some Observations on Iodophilia," Adolph Gehrman, Chicago. (No synopsis.)
2. "The Examination and Commitment of the Insane to Public and Private Hospitals, from a Medical Standpoint," E. L. Crouch, Jacksonville. (Discussion opened by Frank P. Norbury, Jacksonville.)
3. "The Diplococcus of Scarlatinae," W. J. Class, Chicago. (Discussion opened by W. K. Jaques, Chicago.)

#### Abstract.

In this paper I will call attention to its diagnostic importance especially in cases where the rash is atypical. I will also explain some of the difficulties which may be encountered in recognizing the germ and how they may be avoided.

4. "A Sociological View of Criminal Abortion," W. J. Fernald, Frankfort, Ind., non-resident member. (Discussion opened by E. A. Morgan.)

#### Abstract.

The synopsis of the paper runs as follows: It is pardonable to discuss this question of sociology in this Society because the question often presents itself to every physician in requests for the performance of this operation.

Since Society must propagate itself or perish, the constitution of the universe makes sexual intercourse of prime importance; and has set a price on its indulgence which no matter how man may try to avoid its payment, he must pay. The price of legitimate intercourse is the burden of a family. The price of illegitimate intercourse by either husband or wife where the other avoids intercourse because no family is desired, is either disease or a broken home or both. Illegitimate intercourse among

the unmarried brings disease, social ruin or homeless children; while no effort made by those indulging in intercourse to prevent conception, can be certain to prevent it for any extended period without producing impotence in the male, sterility in the female, or both.

Looked at from every point of view, nature has so arranged the safe guards of this, man's greatest passion, that its violation in any degree produces a measure of death in the individual, the family or the state in precise ratio as that violation has been successful. No higher price is demanded for any gratification than for this; for no gratification is the price more rigidly exacted; and the price paid for indulgence in any way to avoid responsibility is death to the individual, the family and the state, none the less certain because it is delayed.

It is our business as physicians to realize the fact and instruct those over whom we have influence. For no one can say with such hope of helping those tempted as we.

5. "The Legal Status of the Doctor," H. C. Jones, Decatur. (Discussion opened by Wm. M. Harsha, Chicago.)

#### Abstract.

Though the physician is, as a rule, a well informed man, it is a fact that he is lamentably deficient in a knowledge of the law in its application to his rights and responsibilities.

\* \* \* not to be expected that a physician should be his own lawyer any more than a patient should be his own doctor, yet a little more knowledge on these points might save much litigation and trouble. \* \* \* \*

The right to practice medicine is not limited or abridged under the common law, which governs in the absence of special enactments, but most of the states have passed laws governing this privilege. \* \* \* \*

It is well for a physician to be sure he has complied with the requirements of the law as otherwise he cannot collect any compensation for his services. To physicians called into neighboring states it is well to know and avoid infringement of their regulations. \* \* \* \*  
In twenty-four states provision is made for meeting resident physicians in consultation. \*

\* \* \* \*  
The law which confers on boards power to grant licenses also gives power to revoke the same for the following causes: \* \* \*

Contracts are either express or implied. If express, they may be written or verbal. All are equally binding, though the stipulations in a written contract are obviously more readily susceptible of proof.

Whenever a doctor undertakes the treatment of a case, certain implied contracts arise depending on the relation of the parties. \* \* \*

He binds himself that he is possessed of "ordinary skill" and experience, and that he will "exercise the same" according to his best judgment," and after "approved methods," \* \* \*  
\* \* \* patient conversely has certain obligations as well as rights. \* \* \* \*

Then third parties, by which is meant interested parties other than the patient, have certain rights and liabilities. \* \* \* \*

"The amount of compensation a doctor shall be allowed is a matter of fact and not of law." \* \* \* That no benefit was obtained is not a bar to recovery." \* \* \* \*

In certain states, notably New York and Maine, a judgment obtained for services is a perfect bar to recovery for mal-practice in the same case. In Wisconsin and Iowa a contrary view has been upheld by the courts. Where the former decision is upheld we are encouraged to follow the amended golden rule, which may be paraphrased thus: Do unto the other fellow what he intends to do to you, but do it first.

6. "Bacteriological Examinations of the Blood, from a Clinical Standpoint," L. Hektoen, Chicago. (Discussion opened by James B. Herrick, Chicago.)

#### Abstract.

Synopsis: "Discussions of the technic; summary of the most important results of systematic bacteriological examinations of the blood recorded in the literature; summary of personal work; the scientific and practical value of the method in pneumonia, typhoid fever, in cases of sepsis, etc."

7. "Educational Opportunities and Needs of our Civil Courts, from a Medical Standpoint," O. B. Will, Peoria. (Discussion opened by Harold N. Moyer, Chicago.)

#### Abstract.

The object of this paper is to draw the attention of the medical profession generally to the growing importance of their relation to the civil tribunals of the commonwealth, both in respect to their mutual value to each other and the educational value of their combined influence to the general public. It is argued that at the present time even the technical requirements are such as to demand greater care and attention on the part of medical men than ever before, and that they should, consequently make a greater effort, through preliminary instruction and constant study, to meet these new and ever increasing demands upon them. It is maintained that the progress of medical science and art, as well as the changing demands of civilized life, is continually complicating rather than simplifying the judicial requirements, and hence the need of greater preparation to meet the issues, and keener recognition of their importance.

The point is made that the courts have virtually become arenas for scientific debate, in which the medical and legal professions are often engaged in striving for the mastery, and consequently offer in themselves educational opportunities of no mean scope and degree. In fact this applies not only to the two professions mentioned, but to the general public, who are always interested in whatever of the kind comes up for consideration and adjudication. No other field offers so good a chance for the profession of medicine to exhibit its influence, power and worthiness before the public, and it should take advantage of it in attempting to secure that consideration in all the demands of life to which it considers its learning and dignity entitled. Attention to this phase of professional involve-

ment should be considered as a valuable opportunity in the scheme of educating the public to that appreciation of professional standing for which we are so constantly contending.

To the above end the author suggests the advisability of the section having consideration of these matters making a routine practice of securing a synopsis of the leading points at issue in the several judicial tribunals during the year, where they involve points of dispute in medicine or surgery, and have them presented for discussion at the succeeding annual meeting of the State Society. It seems to him that nothing could be of greater general value and interest than such a presentation, together with the judgments rendered, and the reasons therefore. Such a course would be of great practical value, and would awaken a lively sense of our responsibility. By way of illustration the author cites a number of actual occurrences during the year, in which medical men were put to a severer test than they ever are in their professional organizations, and draws therefrom the conclusion that it might be well to adopt some such strenuous methods in sifting the wheat from the chaff and getting the best results in medical Society discussions.

8. "Sewage Disposal for Inland Towns." Prof. A. N. Talbott, Champaign University. (Discussion to be opened by C. B. Johnson, Champaign.)

#### Approved Medical Societies.

The applications of the following medical societies for affiliation have been approved by the Judicial Council:

Chicago Medical Society—The Medical Society of Cook County.

Decatur Medical Society for Macon County.

Kankakee County Medical Society.

Cass County Medical Society.

DeKalb County Medical Society.

Stephenson County Medical Society.

Scott County Medical Society.

Marion County Medical Society.

Henry County Medical Society.

Whiteside County Medical Society.

North Central Illinois Medical Association.

E. W. Weis,

Secretary.

### New Incorporations.

The Secretary of State at Springfield has licensed the following corporations:

Woner Medicine Company, Jacksonville; capital, \$400; object, manufacturing proprietary remedies; incorporators. Charles D. Green, Charles W. Correll, George H. Watts.

Murbach Drug company. Chicago; capital, \$2,500; manufacturing patent medicines; incorporators, John E. Murbach, Charles I. Cillmer, Edna B. Murbach.

S. D. Confer Medical company, Orangeville; capital, \$12,000; manufacturing medicines, ex-



tracts, and essences; incorporators, Sydney D. Confer, John J. Moore, Anthony J. Clarity.

Dong Tong Remedies company, Chicago; capital, \$2,500; manufacturing proprietary remedies; incorporators, Dong Tong, Frank E. Makeel, Robert J. Frank.

Cook County Medical association, Chicago; capital, \$2,500; manufacturing medicines; incorporators, Lawrence W. Rowell, Charles E. Wyman, Cheney Moulton.

Class of 1903 of Rush Medical college, Chicago, social and fraternal; incorporators, R. Ralph Ferguson, R. Abercrombie Smith, Edward P. Fick.

Illinois State Medical Society, to promote, the science and art of medicine. incorporators the nine members of the Judicial Council.

Searle & Hereth company, Chicago; capital increased from \$2,500 to \$50,000.

### Marriages, Deaths and Changes of Address.

#### Marriages.

Jas. W. Blan, LaFayette to Miss Mollie Goehring, Warsaw, Feb. 18.

Joseph A. Guertin, St. Mary to Miss Amy Grossaint, L'Erable, Ill., Feb. 18.

Samuel A. Huffman, Chesterfield to Miss Clyde McQuerry, Greenfield, Feb. 26.

John G. McKinney, Barry to Mrs. Electa Henry, ElDara, Feb. 18.

Wm. W. Meloy, Chicago to Miss Charlotte A. Logan, Brooklyn, N. Y., Feb. 25.

Thomas J. Reid, Chicago to Miss Caroline Wolcott, Chicago, March. 10.

#### Deaths.

Bunyan, Walter William, Chicago, March 18, aged 26.

Dugan, James H., LaSalle, March 2, aged 30.

Graham, John, Plainville, Feb. 23, aged 65.

Grigsby, F. M., Springfield, aged 34.

Kittoe, E. R. Galena, February 18, aged 57.

Larkin, James J., Chicago, March 12, aged 49.

McLean, Samuel H., Lincoln-Hillsboro, March 18, aged 53.

McKee, Albert B., Edwardsville, March 17, aged 40.

Thomas, D. E., Lacon, Feb. 5, aged 78.

Woodworth, Gertrude H., Chicago, Feb. 10, aged 55.

#### Changes of Address.

##### Changes to and from Chicago.

Allen, H. Eugene to Montrose, Colo.

Pyrne, John G., from Fort Flagler.

Cambourn, S. A., to Lisbon, Ill.

Loeb, Leo, to Montreal, Canada.

Mueller, Frederick, from Vienna, Austria.

Oaks, J. F., to Dubuque, Iowa.

Rickells, H. T., to Kirkwood, Ill.

Sudduth, W. X., to Billings, Mont.

Wales, A. H., to Lanark, Ill.

Wood, Chas. M., to Maroa, Ill.

##### Changes in Illinois.

Cox, F. P., Farmer City to Peotone.

Lake, J. J., Kenny to St. Louis, Mo.

##### Changes to and from Illinois.

Allen, J. R., Arkansas to Mattoon.

#### Changes in Chicago.

Whamond, A. A., 2109 W. 12th st., to 2097 W. 12th st.

Beechler, L. L., 4601 Indiana ave., to 4337 Grand Blvd.

Abell, Nathan W., 1242 N. California ave., to 898 N. Mozart st.

Nack, Milton H., 406 Reliance Bldg., to 100 State st.

Stout, Alex. M., 804 Stewart Bldg., to 92 State st.

Roach, James J., to 5100 Wentworth ave.

Nichols, J. C., 5123 Wentworth ave., to 5057 State st.

Lyman, H. M., 751 Warren ave., to 200 Ashland ave.

Joyce, Wm. M., 592 E. 43d st., to 576 E. 43d st.

Turck, R. C., Chicago Hospital, 4526 49th st., to 4812 Woodlawn ave.

Dickinson, F., 70 State st., to 169 S. Clark st.

Prendergass, Jos., 863 N. Park ave., to 521 Belden st., Lincoln Park.

#### CAMPHOR LINIMENT.

Septic Absorption Impossible when Camphor Liniment is used.

No matter how powerful the antiseptic properties of a dressing may be it will often fail if it protects the agents of putrefaction by forming a shield of coagulation over them. Wounds often fail to do well because of the coagulating non-solvent properties of the dressing used upon them.

Camphor Liniment is a perfect solvent for dried blood coagulated albumen etc. under which vicious germs take refuge. It penetrates every fold and recess of a wound seeking out and destroying all seeds of putrefaction. It surpasses all other dressing for wounds.

Deep Seated Pain, Sore throat, Frost-bitten feet, Rheumatism are speedily relieved by its use.

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Decatur, Illinois.

**The 1903 Standard Medical Directory**—That the publication of a high-class Medical Directory—correct, comprehensive, attractive and influential—is appreciated by the profession is proven by the cordial reception given the 1902 edition of the Standard Medical Directory of North America and the promising auspices attending the 1903 edition now in active preparation with the aid, so the publishers state from actual computation, of nearly twenty-five thousand correspondents representing every State, province, county, city and town of any size in North America. The new volume will consist of about 1,300 pages comprising complete Directories respectively of the Physicians of all North America, colleges, societies, hospitals, sanitariums, mineral springs, publications and in fact everything related to medicine. The new features (including an Alphabetical Index of physicians with post office addresses and rosters of practitioners of the specialties) will, it is stated, add about one-third to the volume of the work.

# The Illinois Medical Journal.

The Official Organ of The Illinois State Medical Society.

New Series, Vol. IV. }  
No. 12. }

Springfield, Ill., May, 1903.

{ SUBSCRIPTION  
{ \$3.00 A YEAR.

## THE DIAGNOSIS OF CHRONIC INTERSTITIAL NEPHRITIS BASED UPON PHYSICAL SIGNS, CHIEFLY CARDIO-VASCULAR.\*

BY CHARLES LOUIS MIX, A. M., M. D., CHICAGO  
Professor of Medicine, Post-Graduate Medical School.  
Attending Physician to Cook County Hospital.

Pathologically it is easy, on paper, to classify the various forms of chronic nephritis. The usual types are very familiar—the large kidney, which may be (a) the large red or variegated kidney of chronic hemorrhagic nephritis, showing a grayish red surface often dotted with yellow spots of fatty degeneration; or (b) the large white kidney of chronic parenchymatous nephritis, with its yellow mottled cortex often showing hemorrhagic spots. Besides these two types of enlarged kidneys there are two types of contracted ones. Each of the above mentioned enlarged kidneys, provided the patient survives sufficiently long, may gradually shrink until it resumes its normal size, the process being called secondary contraction; so that the term secondary contracted kidney is an eminently fitting one. There is also another form of chronic nephritis called clinically chronic interstitial nephritis, of which the kidney has never been increased in size, but from the very beginning by a process of exceedingly gradual atrophy of the proper renal elements and their partial substitution by cicatricially contracting interstitial tissue, has become primarily contracted; for this form the term primary contracted kidney is eminently fitting.

Clinically attempts at a classification of the various forms of chronic nephritis usually lead to confusion, owing to the fact that transitional forms between the various types exceed in number the typical cases themselves. Indeed one with an ample

clinical experience may easily arrange his cases of chronic nephritis in a series beginning with the large white kidney of chronic parenchymatous nephritis, ultimately arriving at the secondary contracted kidney of chronic diffuse nephritis, which clinically may be scarcely distinguishable from the primary contracted kidney of chronic interstitial nephritis. Indeed some excellent clinicians simply content themselves with the diagnosis of chronic nephritis, without regard to whether the case is one of chronic parenchymatous, or chronic interstitial, or any one of the numerous intermediate forms ordinarily termed chronic diffuse nephritis. However, all physicians will doubtless agree that there is a form of nephritis attended with marked cardio-vascular changes, with little or no oedema, as a rule attacking persons in their third, fourth, or fifth decade of life, often running a course extending from ten to twenty years or more; sometimes almost benign in type, but sometimes suddenly terminating in uraemic coma without a trace of oedema, furnishing a form difficult to distinguish from cerebral hemorrhage. It is of this form which most of all stands out clear-cut among the nephritides, that I wish to speak.

Clinical experience clearly teaches the beginning physician the necessity of being able to diagnose chronic interstitial nephritis which makes up a fair percentage of his practice; for example in 918 medical cases which I have seen at the Post-Graduate Medical School of Chicago, this form of nephritis appeared 29 times, or in a little less than 3 per cent. of cases; and during each of the last two years  $3\frac{1}{2}$  per cent. of the total deaths in Chicago have been due to the various forms of chronic nephritis. A disease which makes up from 2 per cent. to 4 per cent. of a physician's practice demands careful consideration.

Chronic interstitial nephritis is a protean disease, prolific in complications, as a rule

\* Read the meeting of the Illinois State Medical Association at Quincy, May, 1902.

insidious, often latent for years, betraying itself to its victim only by its sequelae. The patient does not come with the complaint of "kidney-trouble" as does the man with the backache; instead he complains of deafness, or of impaired vision, vertigo, neuralgia, sciatic neuritis, indigestion, headache, dyspnoea, epistaxis, some psychosis, or possibly pernicious or at least grave anaemia. Yet behind these diverse complaints, as a rule, a definite set of physical changes, chiefly cardio-vascular, may be found, a thorough knowledge of which enables the physician to make the diagnosis without immediate recourse to the examination of the urine. Indeed, the diagnosis should in all cases be based upon the physical findings, and not upon the chemical and microscopical analyses. The physical examination should invariably be made first, and should lead to the provisional diagnosis; the urinary findings should be used merely as confirmatory evidence.

Some physicians never examine the patient's body for evidences of renal disease; they trust entirely to the analysis of a single specimen of day-urine, which, in a fairly large number of cases, results negatively. The physician who approaches the problem from the point of view of the urinary examination alone, often falls into error. It is, for example, well known on the one hand that cases of chronic interstitial nephritis occur without the presence of albumen or casts in the urine; and on the other hand, many individuals may show casts of the hyaline type without albumen, or albumen without casts, where no nephritis exists. Even acute nephritis has been observed without albuminuria; but of all the forms of nephritis, the chronic interstitial form is the one which most often fails to show albumen. Despite a large number of such cases long since reported by others, I wish to mention briefly three or four additional cases. The first patient was one who suffered from a stenosis of the small intestine, which was not found and relieved, though two surgeons performed exploratory laparotomy. At the two hospitals to which the patient was admitted the customary urinary examinations resulted negatively. I confess that I failed

to diagnosticate chronic interstitial nephritis, the patient not showing the ordinary physical signs of nephritis. This patient subsequently died of his intestinal stenosis. Two primary contracted kidneys were found, to the surprise of those who attended him in his last illness. In this case albumen and casts were never found by any observer.

The second patient is one under my observation during the last year of his life. For a period of three consecutive weeks, some eight months before his death, this patient passed urine which was practically normal in amount, specific gravity, absence of casts and albumen; being suspicious only in its slight reduction of the urea. The patient presented himself with the history of four years of dyspepsia, later associated with intermittent vertigo and some deafness. The cardio-vascular changes demanded the diagnosis of chronic interstitial nephritis, which was immediately made and maintained in spite of the negative urinary findings. An autopsy showed typical primary contracted kidneys.

The third case is that of a patient who nine years ago sought relief from dyspepsia, and in whose case the attending physician made the conservative diagnosis of idiopathic cardiac hypertrophy, rendered plausible because the patient had been a sprinter in his college days, and had seen hard training. Yet five years later when the patient came to me for a follicular tonsillitis and the tension of his radial artery excited my suspicion, I found albumen and hyaline and finely granular casts. I have the positive assurance from this patient that at the time of the diagnosis of idiopathic cardiac hypertrophy, numerous careful analyses of his urine were made, with negative results.

The fourth case is one who shows retinitis albuminurica and albuminuric deafness, who, it is true, shows albumen and casts in twenty-four hour specimens, but who frequently shows neither in single specimens. These cases are only some of several personally observed. The second case and others similar to it which I have met with have led me to believe that in chronic interstitial nephritis, just as there is an undoubted pre-albuminuric stage, there is also after a long



period of polyuria and wasting of renal tissue, a second period or post-albuminuric stage, in which for a time the urine is passed in amounts approximately normal and fairly free from albumen and casts. This latter period marks the stage of extreme atrophy of proper renal tissue, and is, as a rule, rapidly followed by failure of cardiac compensation, and by death.

The necessity, then, of basing the diagnosis of chronic interstitial nephritis upon more constant findings than those obtained from an examination of the urine, must be evident. Physical findings, chiefly cardiovascular, afford a more certain foundation for the diagnosis than laboratory findings.

The *vascular* changes in chronic interstitial nephritis are frequently slighted, yet they merit consideration and are in themselves thoroughly interesting. The arteries, as a rule, present an hypertrophy of both their muscular and fibrous coats, the hypertrophy evidently being an attempt upon the part of nature to compensate for the increased arterial tension, the cause of which is to be discussed later. The arteries are therefore firm and unyielding, far less elastic than normal. Practically they are the arteries of arteriosclerosis, firm, tough and tortuous. Indeed, it is very questionable whether the diagnosis of arterio-sclerosis is not really very frequently a diagnosis of chronic interstitial nephritis. The result of the thickening of the vessel walls is an increased arterial pressure, which by increasing the work which the head has to perform, secondarily leads to additional cardiac hypertrophy. Thus a vicious cycle is established, the cardiac hypertrophy increasing the external tension and compensatory thickening of the arterial wall; and the thickened arterial wall, by decreasing the normal elasticity and vascular arterial area, causing still further cardiac hypertrophy.

The effect just mentioned is produced upon all arteries, whether systemic or pulmonic. The radial artery can be felt; its firmness, toughness and tortuosity are perfectly apparent; but no one can feel the pulmonary arteries and appreciate their changes; hence they are ignored. Yet there is a sign telling fairly clearly of this increased tension

in the pulmonary area, the accentuation of the pulmonic second sound occurring before hypertrophy of the right ventricle and not lightly to be explained away. The text-books have long taught that accentuation of the second aortic sound is present in nephritis; to this dictum can be added another, that the pulmonic second sound is also accentuated. The degree of accentuation of these two valvular sounds is of some prognostic value; if the sounds are but slightly accentuated, and indistinct rather than clear and ringing, there may be present or threatening a failure of compensation. As a rule there is a definite parallel between the amount of tension shown in the radial artery and the degree of accentuation of the second aortic sound; and to the physician who does not know how a renal pulse feels, or to the student who is anxious to learn how to recognize a renal pulse, the suggestion may be given that by feeling the pulse and then listening to the second aortic accentuation he may in time arrive at great proficiency in estimating pulse-tension.

The renal pulse is usually one of abnormally high tension, so high that a capillary pulse is frequently found, just as in aortic insufficiency. The tension is so high that Lepine suggested that it might be in part due to disease of the suprarenal bodies, possibly associated with the renal process. The pulse is also a *pulsus tardus*, the high crest lingering beneath the finger. Often, however, the pulse tension is not increased, especially in all cases of failing cardiac compensation, where the pulse may be frequent and small, easily compressible. Usually the pulse is rhythmical, but toward the end it may be markedly intermittent.

Occasionally it happens that arterial tension is raised so high that hemorrhage takes place. The hemorrhages may be nasal, retinal, cerebral, uterine, etc., occurring wherever a weak artery is found. These are the cases in which, to the layman, the diagnosis of nephritis seems especially strange. I have had cases illustrating all of the forms of hemorrhage, but will mention only one as noteworthy.

Mrs. C. W., age 39. Family history negative. The patient has been accustomed

to the moderate use of beer. Present illness; four years ago, without apparent cause, the patient had a very severe uterine hemorrhage, without history of miscarriage, polyp, etc. She was taken to the Cook County Hospital, where she remained twelve days and was then discharged. She was well till October, 1900, when she had another hemorrhage, for the relief of which she came to the Postgraduate Medical School. Gynecological examination was entirely negative, and she was turned over to the medical department for diagnosis. Physical examination showed the cardio-vascular changes of chronic interstitial nephritis, later confirmed by positive urinary findings. In December, 1901, the patient had a third and very extensive hemorrhage.

The case just mentioned is an excellent illustration of a fact of common knowledge, that chronic interstitial nephritis is frequently a cause of grave secondary or chlorotic anaemia. But chronic interstitial nephritis as a cause of primary, progressive, or idiopathic anaemia, is almost never alleged. The following case is of much interest in this connection. The patient was seen Jan. 13, 1897, two days before her death in the General Hospital at Vienna.

Mrs. X., German, 58 years of age, of slight built, weight about 110 lbs. Previous history: For four years she had suffered from severe anaemia accompanied by occasional epistaxis, sometimes severe. In 1895 she entered Schrotter's clinic, and four months later Neusser's clinic, where she showed signs of a primary pernicious anaemia with macro, micro, and poikilocytes, megaloblasts, and karyolysis with free nuclei. In three weeks she made great improvement, and ultimately left the hospital with the blood findings showing practically a secondary or chlorotic anaemia. The epistaxis ceased, and was looked upon as the epistaxis of anaemia.

Present history: Patient again enters the hospital for epistaxis and dyspnoea. Jan. 13, 1897. The blood shows 928,000 erythrocytes and 17½ per cent. haemoglobin. The color index is about unity, 35/37. Leucocytes 700, with the propartem of 1 to 1,180 erythrocytes. Marked macrocytes,

microcytes and poikilocytes; no nucleated blood corpuscles, and hence a serious prognosis. The coagulation power of the blood is greatly reduced. The nose shows merely a few dilated veins. The heart is increased to the left to the mamillary line, evidently a dilatation from anaemia, the pulse being so small as to be scarcely perceptible. Loud systolic murmur over the whole cardiac area, loudest at the base; venous hum in the neck. No accentuation of the second sounds. Urinary examination on this and all other occasions entirely negative, though made very carefully and frequently on account of the known relation of epistaxis to nephritis. The diagnosis made was primary pernicious anaemia, if there be such a thing; but most likely a secondary pernicious anaemia of unknown etiology. The patient lived but two days. At the autopsy Prof. Kolisko, to the surprise of all, found as the only pathological condition, two very small primarily contracted kidneys. The heart, due to the grave and persistent anaemia, had never been able to hypertrophy and so to give the usual cardio-vascular signs of the disease; and the negative urinary findings were probably due to the fact that almost nothing of the proper parenchymia remained to produce casts or albumen.

Aside from epistaxis, which is said to mark either the beginning or end of the malady, and the occurrence of which in the fourth, fifth, or sixth decade of life should excite the suspicion of chronic interstitial nephritis, cerebral hemorrhage is the next most common form of hemorrhage. About 20 per cent of all cases of chronic interstitial nephritis die of it. Hemorrhage from the ear is frequently renal, and the term proposed, of myringitis, or tympanitis albuminurica, is justified. Retinal hemorrhage is by no means uncommon. A patient admitted last winter at midnight to the Mercy Hospital on account of an uncontrollable epistaxis, was blind in his right eye, and had been so for two years. The blindness was due to retinal hemorrhage, and this hemorrhage and the epistaxis were due to chronic interstitial nephritis.

The *cardiac* changes are exceedingly valuable from a diagnostic standpoint. Inspec-

tion shows much: the apex-beat is often seen in the sixth interspace, usually as far out as the nipple-line. An epigastric pulsation (not the worthless sign that some conceive it to be) is usually present. Rarely a pulsation may be seen in the second right intercostal space, the visible manifestation of an intense accentuation of the aortic second sound. The suprasternal notch is generally full.

Palpation shows a vigorous heart-beat. The apex is felt sometimes in the fifth, but usually in the sixth interspace, or perhaps behind the sixth rib, in the nipple line, or farther toward the axillary line. The apex-beat may be sharp, but is often diffuse, extending over a fairly wide area, due to the rounded apex of the heart. Occasionally the closure of the aortic and even of the pulmonic valves can be felt. More important than these signs, however, is the pulsation which can be felt in the suprasternal notch. The pulsation is transmitted either from the transverse arch of the aorta, which normally should extend no higher than one inch below the supra-sternal border, or from the three great vessels springing from the arch, the innominate, and left carotid and subclavian arteries. In chronic interstitial nephritis, aortic insufficiency, aneurysm, failure of compensation in all forms of valvular disease, and in a few other much rarer conditions than those just mentioned, this sign is met. In the 29 cases previously referred to, this sign was always present, and it is a very convenient one to get at in either man or woman. Given a hard radial pulse and a suspicious anamnesis it is my custom to insert my finger into this notch, asking the patient to bend the head forward so that I can better feel beneath the manubrium; and if a pulsation is found, full physical examination is at once asked for. Personally I regard a palpable pulsation in the suprasternal notch as of much value in finding the presence of chronic interstitial nephritis.

Percussion is of value in substantiating the results of inspection and palpation, but is often made difficult by a coincident emphysema. The outline of the heart in

chronic interstitial nephritis is fairly characteristic; it most nearly resembles the heart found in aortic insufficiency. It is as a rule elongated, the apex being in the sixth space in typical cases, and the transverse arch of the aorta nearer the notch than is normal. The area of dullness usually extends only to the midsternal line; if it be found beyond that, there is hypertrophy of the right ventricle. To the left there is dullness as far as the upper-line at least, and usually beyond it, such increase, however, being frequently annihilated by emphysema. In extreme cases the dullness extends to the anterior axillary line, such a large increase usually meaning a dilatation added to an hypertrophy.

Auscultation is quite as valuable for its negative findings as for its positive ones. The most characteristic auscultatory signs are the accentuations of the second aortic and pulmonary sounds, the latter not infrequently being louder than the former. The heart-sounds are pure, yet the first sound is sometimes indistinct, seemingly muffled, and prolonged; it may be reduplicated. As a rule both sounds are increased in strength. If there be failure of compensation, a *bruit de galop* may be heard, all four sounds being made separately owing to a lack of synchrony between the contractions of the ventricles and the closure of the semilunar valves. Murmurs are not present except when compensation has failed, when the systolic murmur of a relative mitral insufficiency may develop from a stretching of the ring of insertion of the mitral flaps, caused by the dilatatio cordis. An absence of murmur is not necessarily proof that a relative mitral insufficiency is not present.

The differential diagnosis between valvular disease and chronic interstitial nephritis can be made largely from the heart alone, without recourse to special symptoms, especially retinitis albuminurica which is exceedingly valuable. It is never a case of valvular disease in general which must be differentiated, but rather mitral insufficiency. Aortic stenosis, for example, besides being exceedingly rare, could not possibly



be mistaken for chronic interstitial nephritis; neither could uncomplicated mitral stenosis be so mistaken. The small pulse alone, and the shape of the heart, if an additional diagnostic point is needed, suffice for the differentiation. Aortic insufficiency, by the shape of the heart, its elongation, the apex appearing in the sixth space, and the high tension of the pulse may occasion confusion; in aortic insufficiency, however, there is a *pulsus celer et altus* and in nephritis a *pulsus tardus*. The absence of the diastolic murmur in nephritis is, of course, the valuable differential point. Mitral insufficiency alone or in combination with stenosis is not easily differentiated. In general, however, the hearts differ in the two conditions, in the area of dullness, valvular hearts showing marked increase to the right, nephritic hearts showing only slight increase in that direction. As a rule the apex is in the fifth interspace in mitral insufficiency, and in the sixth in nephritis; in mitral insufficiency the pulmonic second sound is much accentuated, being invariably much louder than the aortic second sound, whereas in nephritic hearts the aortic second sound is more accentuated than the pulmonic, with few exceptions. Nephritic hearts, unless a relative mitral insufficiency be present, show no systolic murmur, whereas mitral hearts show its presence; moreover the history of the patient is valuable, often showing a possibility of an endocarditis and sometimes seeming to show that an endocarditis could never have been present. Sometimes the question as to whether a given insufficiency is relative or absolute cannot be settled, albumin and casts in the urine being explained either as due to a chronic interstitial nephritis or to a chronic passive hyperaemia of the kidneys. Here the signs of uraemia, toxæmia, retinitis albuminurica, deafness and hemorrhages must be sought for, so that the anamnesis is, of paramount importance, though it must be secured in a non-suggestive manner, to be of value.

The cardiac hypertrophy in chronic interstitial nephritis is so important as to deserve more extended consideration. According to Traube's old statistics, 93 per cent.

of cases show the hypertrophy, only 7 per cent. being without it. The hypertrophy is both concentric and excentric; that is, hypertrophy may take place without dilatation, or there may be some dilatation with subsequent hypertrophy. The separation of these two types is clinically impossible and pathologically useless. As a rule the left ventricle is the portion most hypertrophied, the right ventricle not increasing in size until the left ventricle shows signs of failing compensation. The right ventricle may be primarily hypertrophied on account of increased resistance in the pulmonary circulation. If the two ventricles appear to hypertrophy simultaneously, the increase may possibly be due to toxic irritation of the myocardium, if we are to believe Dickinson. As a rule the degree of hypertrophy is extreme, the heart weighing from two to three times its normal weight, so that the term *cor bovinum* is with propriety applied to it.

Aside from the suggestions just mentioned as to the cause of the cardiac hypertrophy, there are two theories advanced, the mechanical theory of Traube, dating back to 1856 and the chemical theory of Bright himself. According to the mechanical theory of Traube the partial obliteration and destruction of numerous small blood-vessels in the kidney by the increase of interstitial tissue and its secondary shrinking, raises the arterial pressure. Yet it is a fact that ligation of an entire renal artery does not raise the pressure, much less the ligation of a few small branches. More plausible is the extended mechanical theory of Gall and Sutton, who believe that all cases of chronic interstitial nephritis begin in the capillaries of the systemic circulation, and that this capillary fibrosis necessarily raises the blood-pressure to such an extent as to produce secondary cardiac hypertrophy. Apparently in support of this is the undoubted fact that slight cirrhosis of the liver and of the pancreas accompany pronounced cirrhosis of the kidneys; yet it is quite possible that the hepatic and pancreatic cirrhosis are not simultaneous but rather secondary processes. The keenest blow against this theory is the

one dealt by the pathologists; investigations do not substantiate the fundamental basis of a capillary fibrosis.

The old theory of Bright himself, the one to which clinicians have wisely reverted, is the chemical one. Due to the retention in the blood and body of constituents which ought to be eliminated, materials which cause an increase of arterial pressure, the work of the heart is increased and the hypertrophy follows. This hypertrophy occurs in all cases of nephritis, both acute and chronic, provided the condition of the patient be not too bad for hypertrophy to take place at all; and since the theory satisfactorily accounts for the rapid hypertrophy and increase in pulse tension seen even in the short course of an acute nephritis, I am very willing to accept it, leaving it to the physiological chemists to find out what the irritating substances really are. There is, at all events, from the irritation of toxins a primary contraction of the smaller arterioles; this contraction raises arterial pressure, and so causes cardiac hypertrophy.

Cardiac hypertrophy in nephritis is thus nature's curative process; the increased cardiac power promotes increased diuresis for the purpose of sweeping out the toxins. Why there should be these toxins in nephritis, is a question as yet wholly unsolved. Lepine, as before mentioned, casually suggests that the suprarenal bodies may be at least physiologically affected in nephritis, and so raise arterial pressure by causing arterial contraction. Whatever the cause of the hypertrophy, it at least prolongs the patient's life, and its good or poor-development should greatly influence the physician's prognosis. The hypertrophy is the condition which the physician should strive to establish. It has two vast advantages: first, it provides for better elimination of toxic matter, and secondly, it keeps down the oedema. Oedema in general is due to blood stasis in the capillaries with transudation of the serum. The hypertrophied heart supplies an increased *vis a tergo*, hurrying the blood stream along, and according to Dickinson, by the suction-power of the auricles and ventricles, pulls the blood out of the

venous capillaries, sucking it toward the heart. This suction-action, not apparent in a normal heart, is said to be pronounced in an hypertrophied one.

The hypertrophy has its disadvantages as well as its advantages: hemorrhages are apt to take place. Haematuria is exceedingly rare; epistaxis, hemorrhage from the bowels in the rare cases showing intestinal ulceration, retinal hemorrhages with amaurosis, auditory hemorrhages, and most of all, cerebral hemorrhage, afford the chief dangers. In treating a case, therefore, the physician must use great judgment; it is his duty to keep an even tension in the radial pulse. Cardiac stimulants should never be given unless cardiac failure is evident; and when arterial pressure is very high it should be lowered by nitroglycerine or the nitrites. Their timely administration may prevent cerebral hemorrhages. Undoubtedly epistaxis is a conservative process and does the patient good instead of harm; it is certain that the pulse is better after a moderate epistaxis than before it took place.

Hypertrophy occurs in all cases except in the weak and debilitated patients who cannot store up enough nourishment to enable the heart to hypertrophy. Nephritis in the very old, the tuberculous, and the cachectic, is not attended with hypertrophy. Besides these cases there are a few cases of vascular hypoplasia first noted by Lancereaux two decades since, and subsequently by Dieulafoy. Besancon, and other French observers. Accompanying the vascular hypoplasia is a chlorosis and a nephritis. I saw such a case myself in Vienna, in a girl of 18 years of age. Some dozen or so of these cases with autopsy have been reported, the nephritis being substantiated by post-mortem examination, the hearts in all cases not only being not hypertrophied, but even smaller than normal, with small aortae. Lancereaux is of the opinion that the vascular hypoplasia extends as far as the kidney, and so is responsible for the renal atrophy. Dieulafoy has named the condition *chloro-Brightisme*. The hypoplasia is in general an indication that the developing force in the patient is poor; that it is exhausted even

before the adult stage is reached. If a pathological condition arises, not enough developing energy remains to make possible the cardiac hypertrophy. Hence these cases very rapidly succumb, being deprived of the benefits of hypertrophy.

Not at all infrequent, according to the best observers, notably Sansom, is an associated pericarditis in the late stages of chronic interstitial nephritis. Within the last six weeks I have had such a case, where the diagnosis is at least hydropericardium, if it be not a true pericarditis; but since there is no demonstrable ascites, and merely a trace of hydrothorax the diagnosis of pericarditis is fairly sure. The patient, aged 38, came to my clinic April 9th complaining of great dyspnoea and pain in the left abdomen. He felt a ball in his stomach, a striking symptom in this connection. His greatest grievance was that he could not walk a block without sitting down on the sidewalk to rest. Orthopnoea was absolute; he had not been in bed for two weeks, and even after two weeks of treatment he could lie down for only a short time. Examination showed a bulging forward of the left chest, a muffled and subdued heart-beat, a typical pear-shaped area of dullness, but nothing on auscultation. No friction rub could be heard, merely a change in the clearness of the heart sounds with change of posture. The sign of abdominal pain is important in connection with this form of pericarditis, according to Sansom, and was the second complaint which the patient made as to his condition. Both Dickinson and Sansom insist in the prevalence of pericarditis toward the termination of cases of chronic interstitial nephritis, the pericardial thickening often being quite extensive and greatly increasing the weight of the whole organ. Pain in the abdomen or no pain at all are characteristic of this condition.

Another striking feature in chronic interstitial nephritis is the absence of oedema of the renal type. Oedema of course occurs, but possibly almost never on account of disease of the kidneys, rather, on account of failure of cardiac compensation. Some cases of chronic interstitial nephritis, dying

suddenly of cerebral hemorrhage or uraemic coma, may show no oedema at all. Others may show it only shortly before death. When oedema occurs, its distribution is quite unlike that of chronic parenchymatous nephritis. The oedema of nephritic type is an aggressive affair, the oedema from cardiac failure a more passive process. The former produces great turgidity of the face, especially puffiness of the eye-lids, and swelling of the scrotal sac. The cardiac oedema is rather confined to the extremities, an ascites, and hydrothorax.

The special sense organs show changes so characteristic as to demand some mention. Retinitis albuminurica, producing an amblyopia is one of the earliest evidences which the patient may show; and it is common knowledge that oculists are frequently the first to make the diagnosis. The onset is as a rule extremely sudden, like the onset of uraemia. For example, I was called Oct. 23, 1901, to see a patient of 62 years who said she had never been sick and was not then sick, but that something was wrong with the right eye. She had been driving the day before and the day being a windy one, she attributed the slight blurring of vision to dust. By the following morning the dimness had increased to such an extent that with the affected eye persons could not be recognized at a distance of a few feet. The suggestive history prompted palpation of the radial artery and the suprasternal notch, and further examination of the heart itself abundantly justified by its findings the diagnosis of chronic interstitial nephritis. Treatment was immediately begun. On the next day a twenty-four hour specimen of the urine showed albumin and casts, and the oculist reported a retinitis albuminurica. The report of the oculist was accompanied by a prognosis of a six months life expectancy, despite the patient's fairly good condition, because the retinitis was looked upon as a fair measure of the general amount of vascular degeneration present. Seven months have passed, and the patient is better than ever. I find two years given by oculists as the extreme limit in these cases. I protest against this prognosis because I



have followed two cases who have already passed beyond the two year limit, and Dr. Arthur Edwards informed me that he recently performed an autopsy upon a patient showing distinct albuminuric retinitis as early as 1894. In amaurosis due to retinal hemorrhage or to a neuro-retinitis, the prognosis is said to be worse than in amblyopia; yet I have seen a patient who two years previously had a retinal hemorrhage.

Analogous to the retinitis albuminurica is the deafness frequently found. Tests will show at once that it is a nerve-deafness, and not a deafness due to defect in the conductive apparatus. As a rule, renal deafness is associated with tinnitus aurium, or may be preceded by it for a period of two or three years. Often there is an associated vertigo. The deafness and the vertigo are characterized by fairly large oscillations, being much more pronounced on some days than on others. It will be observed that the defects of sight and hearing occur in the case of two cranial nerves that are not true nerves, but rather outgrowths of the brain itself. It is an interesting question whether the third embryological cerebral outgrowth, the olfactory tract, bulb, and nerves, do not react to toxins in the same manner as do the second and eighth nerves. Doubtless it will be found, if careful histories are taken, that smell, too, is subject to defect in chronic interstitial nephritis.

#### Discussion.

**George W. Webster**, of Chicago: Mr. Chairman.—I do not like to let so interesting a paper as this be passed by without at least a word of commendation. It seems to me that this is a matter of exceedingly great value, because the average practitioner depends for his diagnosis of nephritis upon an examination of the urine. He particularly expects to find albumin and casts. I think it is unusual for the general practitioner to carefully estimate the actual work of the kidneys, as shown by the total solids excreted, and the total urea in twenty-four hours, having due regard for the character of the diet of the patient during that time. Under these circumstances, where that is not done, the diagnosis is not correct, but where we have due regard for the points that have been laid down by Dr. Mix our diagnosis cannot be otherwise than correct. To recognize the existence of cardio-vascular changes is of the utmost importance to the diagnostician when considering cases of nephritis, and I think that these

conditions are too often overlooked by the average practitioner.

**L. H. Mettler**, of Chicago: I would also like to speak from clinical standpoint. I hope that the Doctor, in closing his discussion, will give us just a word or two in regard to any other signs, especially neurotic indications, that would help us very much. I sometimes feel that when cases come to me manifesting certain disturbances of the nervous system of an indefinite character, which are referred to and classified under that peculiar unsatisfactory name, the neuroses, I have sometimes felt that if we look to the kidney, particularly the alterations in the circulation, that we might find some explanation for that. I have no idea what the nature of these cases may be; whether it be due to a slight toxic condition in these cases of chronic nephritis is uncertain, but I have often observed cases of a neurological character, manifesting a slight degree of insomnia, a little malaise, possibly slight loss of memory, that were not true cases of neurasthenia. I have been very uncertain as to what to call them, and where to place them. Sometimes I have suspected what I would call a renal insufficiency, and by treating that condition I have found some of these slight neurotic symptoms and manifestations to clear up. Whether that hit directly upon the etiologic cause, I do not know, but quite a number of these mild forms of neurotic disturbances have seemed to me to be almost directly due to some disturbance in the function of the kidney. Therefore, I am especially interested in this paper, which shows us how difficult it is to diagnose the renal condition. It seems to me that with a little information on the line of possible nervous manifestations associated with these obscure conditions, outside of what we can detect through the pulse and heart, might be of some assistance to us in making a diagnosis.

**J. W. Hensley**, of Peoria: I should have been pleased to have heard the paper in its entirety, but with reference to the neurotic conditions that may present themselves, let me say that many times a patient will go from one physician to another, one finding albumin and another not finding it. I have had such experiences myself, but towards the latter end of these cases of interstitial nephritis I think we show that we have a disturbed vision, or sometimes disturbance in digestion, or in the hearing, and to my mind they are important diagnostic points. This is especially true in cases of interstitial hardening of the kidney. It is very plainly to be seen why we may not have albumin. The kidneys are so hard that they cannot secrete or throw off the albumin or casts. Symptoms affecting the eyes, the heart, the brain, and the digestive tract are of great importance in making a diagnosis of this condition.

**R. B. Preble**, of Chicago: I should like to add a word of commendation because the matter is of the very greatest importance, and the paper again draws attention to the fact that Bright's disease of the kidney is not a disease of the kidney itself but a disease of the entire cardio-vascular system, and probably the commonest form of disease of this system,

showing itself particularly in chronic inflammations of the kidney fails to give albuminuria. It is important to draw attention to the fact that albuminuria is not necessarily an evidence of chronic inflammation of the kidney, as we may have albuminuria and casts without there being anything present of the disease which we ordinarily understand under the term of Bright's disease. It is important that the attention of the profession should be drawn to the fact now, when we find scattered through the literature of the past few years, and constantly increasing in number, interferences by the surgeon in cases of Bright's disease. Only a few months ago one of the prominent surgeons of New York reported eighteen cases of Bright's disease cured by operation. Yet all but the last two were as free from Bright's disease, according to the report, as any could be. His report shows that there is a tendency to operate in these cases with the idea that they are local diseases of the kidney. They are not local diseases of the kidney, but diseases of the entire vascular system, and any paper, particularly so able a paper as this, which draws attention to the fact that the disease commonly known as Bright's disease is not a local disease of the kidney, and that albuminuria and casts are not necessarily an evidence of nephritis, is to be commented upon and scattered broadcast. I am particularly interested in this phase of the subject, because I have at present collated the literature, and shall present to you shortly a review of cases of so-called nephritis which have been treated by surgical means.

Dr. Mix (closing the discussion): I thought it wise not to say anything in my paper about the neuralgias which are so common in nephritics. I had a case about three weeks ago, a lady, who had been to see nine doctors before she came to see me. Of this number, only two made a urinary examination; one reported no albumin present, and the other, who made the examination right in the office while the patient was waiting and watching, reported no albumin. He said that she had a case of supraorbital neuralgia, and treated her accordingly. She got tired of him, and thought she would try another. I was the next man. I made the diagnosis of chronic interstitial nephritis, and my treatment was directed toward the elimination of the toxins, physiological chemistry will have to tell us what they are, but since then there has been very marked improvement in her case. The changes which take place in the retina and in the brain and cord membranes, to which the terms meningitis albuminurica may properly be applied, and other changes, as, for instance, the association in the late stages of chronic interstitial nephritis with pericarditis, are very interesting. The length of my paper simply justified me in making mention of these combinations. Sansom, Dickinson, and other authorities of the English school, insist upon this association, and I have at the present time under treatment a negro who shows this very combination. He is thirty-eight years old; he came to me about six weeks ago, when he was unable to walk a block without sitting down on the sidewalk

and resting himself. The orthopnea was terrible. He could not lie down at all for over two weeks. He showed the ordinary typical changes of pericarditis with hydropericardium, but without very much hydrothorax or ascites. I made a diagnosis of pericarditis, in spite of the fact that there was no friction sound. A very vague and interesting feature in the case was cough, and, second, a very severe pain in the left abdomen, which led me to the diagnosis very quickly, because this is one of the manifestations of renal pericarditis.

Another point which I wish to mention is the effect of the nephritis on the alimentary canal, both the stomach and intestines. Dickinson collected some twenty-two cases of dyspepsia which showed ulcerations of the small intestines, usually in the region of the ileum, associated with chronic interstitial nephritis. These cases are also usually associated with pronounced diarrhea. This is very common in old people without any other signs of uremia, and if this diarrhea is mistaken, as it usually is, no improvement follows the treatment. The diarrhea sometimes stops instantaneously, and is followed by most obstinate constipation, so that operations have been done in cases of Bright's disease for a supposed obstruction of the bowel.

### MALARIAL HAEMATURIA WITH ETIOLOGY, SYMPTOMS, DIAGNOSIS AND TREATMENT.\*

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I do not expect to add anything new to the literature on this subject, but having practiced for fifteen years in an intensely malarial locality, where the disease is quite prevalent, and knowing that it is very rare in some localities many physicians having never seen a case, I thought some relation of my experience might be of interest, especially to the younger members of the profession.

I will mention though, here, that while I have met in late years with more than the average of success, that my treatment is not always successful, and if any one of you should meet with a case of Swamp Yellow Fever, as it is sometimes called, you will have your hands full, and most likely after you have applied all your medical skill and exhausted all your resources, both practical and theoretical, the patient will quietly slip from your hands into the great beyond. For, in my opinion, there is no disease more

\* Read at the 52d Annual Meeting, Quincy, May 21, 1902.



surely fatal, if not properly treated, than a case of Malarial Haematuria.

I shall not enter into the pathology of the disease more than to say that it seems to occur as the result of profound malarial intoxication and that the malarial poison acts upon the blood and the bloodvessels impairing the integrity of both, destroying the blood discs and weakening the capillaries so that they permit the transudation of the blood elements, usually retained, and also generating toxins in the blood, hemoglobin being probably set free in the destruction of the red blood corpuscles and other poisonous substances that the overworked diseased kidneys and liver are unable to excrete. The Spleen and Liver are generally much enlarged and tender. There is also a probability of a nephritis in every case.

#### ETIOLOGY.

Practitioners of the Southern States, where the disease is very frequent, are much divided in their opinions as to the cause. Three theories are advanced—the Malarial, the Quinine and the Specific theory.

The first assumes that Malaria is the sole and only cause, and much evidence is adduced in support of the position. The fact that the disease occurs only in malarious localities, that there is always a previous history of malarial attacks and exposure to malarial infection, that the disease occurs only in persons who neglect to treat themselves properly for malaria, and that malarial poisons only produce the pathological conditions found in hematuria, seems to be convincing evidence in support of the malarial theory. On the other hand, there are many reputable physicians and some of world-wide fame, who claim that the administration of quinine is a most active agent in producing the disease, and that hematuria is nothing more than a quinine intoxication.

Koch, in studying the black water fever of Africa, which is the hematuria of the States, says that quinine plays a very important role in the etiology of the fever, and that in nearly all cases he failed to find the malarial parasites.

Doering of Germany, says that quinine in association with active malarial parasites, has almost always been recognized as the important provocative cause of the disease.

Other observers in the Southern States have failed to find the plasmodium malariae and are led to believe that the drug, if it does not cause the disease, is contraindicated as a remedy.

The Specific theory has not a few advocates who claim the disease is caused by a specific infection from some microbe or variety of bacteria, but I think they have failed to isolate the gentleman, or at least to prove his identity.

The Malarial theory as to cause though, is the one most generally accepted by the rank and file of the profession; men who live and practice among the people who are subject to the disease, and who base their views on close observation and practical experience gained at the bedside, and not on high spun theories and visionary deductions.

I have never known a case of the disease to occur in a person who took quinine in sufficient doses and at the proper times, to prevent or cure malaria, but in every case where the patient's history could be accurately traced, there had been a neglect of this precaution, they had not taken much quinine or were taking something else that they thought just as good.

The diagnosis is not usually difficult. The surroundings and history of the patient, the fact that he lives in a malarial locality, that he has previously suffered from malaria, the high temperature, the absence of pain during micturition, will very materially assist in the diagnosis.

We must distinguish from a hemorrhage caused by calculi, cancer, septicaemia and from the effects of drugs and poisons; but while pain more or less intense accompanies all these diseases, there is none in malarial hematuria. The urine is voided easily and often unconsciously and there will be no indications of the use of drugs.

#### SYMPTOMS.

There are two forms or types of the disease which I shall designate as the mild and the malignant.



The former consists of repeated mild attacks of hemorrhage from the kidneys, usually intermittent in character. There is no jaundice, or very little, the temperature never runs high and is readily amenable to proper treatment.

The malignant form, which I shall mainly consider, is usually ushered in with a chill, sometimes light, but more often of a congestive nature. There is always a history of malarial exposure, the patient has been having chills or headaches and fever, or the attack may begin without any premonitory symptoms; the temperature is high the extremities cold, the tongue dry and brown, the pulse feeble and often imperceptible at the wrists, the facial expression is anxious and there is a striking appearance of depression. The urine black, often tarry in looks and consistence and is passed in unusually large quantities, often a quart every hour, sometimes a couple of gallons in a few hours; after 24 hours the quantity is much diminished and the color grows lighter but persists for two or three days. Rarely, however, there is complete suppression of the urine, a very grave complication.

Nausea, very difficult to control, and vomiting of a bilious and even black matter occurs. Distressing attacks of hiccoughs that weaken the patient and greatly aggravate the case, are often encountered. The nausea is often so extreme that nothing will be retained on the stomach, not even a teaspoonful of water. Intense jaundice comes on in from two to six hours. The temperature may reach 106 or 107. Drowsiness and coma come on early which may rapidly increase until death closes the scene; others are conscious up to the moment of death, which may occur in from twelve to twenty-four hours. Sometimes the symptoms rapidly subside and are repeated on the following day, especially if not prevented by treatment. The patient is often extremely nervous and restless, shifting his position every moment. Should this condition continue long, it indicates a grave case and is soon followed by coma that ends fatally. If the patient recovers, convalescence is slow and

tedious, being for weeks in an enfeebled and anemic condition.

#### TREATMENT.

The treatment is a subject which admits of much discussion, particularly in reference to the administration of quinine, some advocating the early and persistent use of the drug, and others condemning its use altogether, or at least until late in the disease. I must certainly confess that I have never been able to perceive the results claimed for it by the authors of our text books, and I am of the opinion that the practitioner who pins his faith to it to the exclusion of other more potent drugs, will lose the most of his patients. I believe quinine to be a germicide to the plasmodium of malariae, but not to the toxins they produce in the blood.

Hematuria is a toxemia, being caused by retained poisons within the circulation over which quinine has no power to eliminate. Elimination of these toxins by the bowels and the kidneys, is our first imperative duty, then afterwards, fortify the system against them by the use of quinine and other tonics.

The liver and kidneys are always found in an engorged and inactive condition from the impoverished state of the blood and will not be able to excrete the foreign matter from the circulation without assistance, and the treatment, in order to be effective, must be directed toward these organs, and what is done must be done quickly. Homeopathy and infinitesimal doses have no place in the successful treatment of malarial hematuria. Vigorous efforts should be made at once to move all offending material from the alimentary canal by brisk purgation, which will indirectly aid the action of the liver and the kidneys. Calomel and epsom salts, the mercurial in from 5 to 40 grain doses can be given until three or four doses are taken, always following with the saline. Calomel is preferred of all purgatives because it is not only one of the best antiseptics we possess, but in addition to its purgative action, has splendid diuretic properties, and because of its small bulk and weight is not easily heaved or vomited up, and combined with the salts has a good

mechanical effect also, if you will allow me the expression. It is the remedy par excellence in all severe malarial affections.

While waiting for the purgative to act, vigorous and persistent efforts should be made to counteract the congestion of the internal organs, always present. Ice should be applied to the head, heat to the feet and the circulation should be stimulated by friction to the skin until reaction sets in. As a means of precaution, 5 grains of bisulphate of quinine should be administered hypodermically, every half hour until three or four doses are given. After reaction occurs, if there is much nervous excitation, small doses of morphia and atropia are very useful. The action of the purgative should be assisted by copious injections per rectum of warm water and soap suds or salt solution repeated every half hour until good effect.

With the above treatment, combine an active diuretic, preferably one of the potash preparations. To control the hemorrhage give spirits of turpentine every three or four hours in 1/4 to 1/2 dram doses. The high temperature should be controlled by the sponge bath. I never use the coal tar products in this form of malaria.

For the nausea, crushed ice should be given, lime water and bismuth subnitrate, to which small quantities of morphia or cocaine in solution, may be added, mustard plasters over the stomach, and I have had good results from chlorodyne internally.

Hiccoughs can best be controlled by the hypodermic injection of morphia or by Hoffman's anodyne by the mouth.

No hard and fast rules can be laid down for the treatment of these complications, we must meet the conditions as they arise. Heart failure sometimes comes on rather suddenly and when least expected; for this, the subcutaneous injection of the normal salt solution is probably as good a remedy as any. Just as soon as the bowels and kidneys respond to the medicines, begin with quinine, Fowler's Solution and tincture of iron or iron with strychnine in solution, and keep up the treatment for several weeks to prevent relapses.

The diet should be restricted to easily digested foods, and stimulants of whiskey or brandy can be prescribed freely.

#### REPORT OF CASES.

The following cases have been selected from my case book as typical of the malignant form of the disease.

Case 1. I was called to see a little girl, aged eleven, March 18th, 1893. She was in a comatose condition, hands and feet cold, temperature 104 1/2, pulse very fast and feeble. She had passed about a gallon of urine that appeared to be nearly all blood.

Ten grains of calomel were given dry on the tongue and washed down with water. She also had a hypodermic of five grains of bisulphate of quinine and morphia 1/8 grain. Two more doses of calomel were given followed by four doses of epsom salts, each a teaspoonful one hour apart. Five drops of turpentine were given every two hours. The next evening the hemorrhage had ceased, the temperature was 102 and consciousness had returned. She was then put on quinine, Fowler's Solution, and the muriated tincture of iron, and made a rapid recovery.

Two years later she was attacked in the same way and manner and only lived 24 hours. She had moved further away and I saw her two hours before her death; she then had a temperature of 105 1/2 and was unconscious.

Case 2. September of the same year, was called to see a gentleman 76 years of age; he had been having chills and remittent fever during the summer and had been taking chill tonics, etc. His temperature was 104, no pulse perceptible. He had passed with his urine a small quantity of blood then had been unable to urinate more. Suspecting enlarged prostate, I endeavored to pass a catheter but failed. Consultation was called and paracentesis was performed. The bladder was found to be full of coagulated blood that we found impossible to remove. Purgatives, diuretics, hot and cold applications were tried without effect. He gradually sank into unconsciousness and died on the fourth day of the attack.

Case 3. A gentleman 40 years of age, came under my care in October following; temperature 104, pulse 90, was slightly jaundiced and was passing blood with the urine every few minutes, and was very much frightened. He had been having chills and malarial symptoms for two weeks previously, but had had no decided rigor. He was immediately given a thorough purging with calomel and epsom salts, calomel 10 grains, bicarbonate soda 10 grains, three doses. This was followed by a tablespoonful of salts one hour apart, four doses and 20 drops of spirits of turpentine every two hours, until the hemorrhage abated. The next day he was a great deal better and was then put on Fowler's Solution 5 drops tincture of iron, 20 drops three times a day and quinine and Dover powder 10 grains of the former every three hours for twelve doses. Quinine was not given until 24 hours after first called. He made a rapid recovery and has not had another attack since.

Case 4. August, 1898, a lady 20 years of age recently married, had been having chills but had taken no medicine or very little. She was suddenly attacked by a severe chill accompanied by profuse bloody urine that was passed every few minutes. Her temperature two hours after was 106, pulse barely perceptible and extremities cold, patient was unconscious. Ice was applied to her head and her feet placed in hot bath. She was given dry on the tongue, 40 grains of english calomel one dose and washed down with water by prying the teeth open. Later, epsom salts, one large tablespoonful one hour apart, four doses and dose of calomel repeated.

Copious injections of warm water and soap suds were given. These produced large stools of a tarry looking substance. The next morning she had regained consciousness, had a temperature of 103 and pulse 110. She was intensely jaundiced and had obstinate hiccough and vomiting. After these were allayed she was put on Fowler's Solution, iron, quinine and strychnine and made complete recovery, and is now a strong and hearty woman.

The high temperature, the heroic treatment and desperate condition of this woman during the attack, are notable.

Case 5. September, 1898, a young man 24 years of age, had a violent chill in the morning and when I saw him late in the evening, was apparently suffering from maniacal excitement, whether caused by fever or fright I could not determine. He was very restless and talking all sorts of nonsense, he was every few minutes passing large quantities of blood, great drops of perspiration stood over his face and his skin was intensely yellow. His mother was charging that he had been poisoned and I was puzzled at first just what to do, but soon concluded that the poison was only malaria. I found his temperature to be 105, hands and feet icy cold, pulse hard and tense beating 140 per minute. His bowels were loose resembling cholera and his vomiting resembled the black vomit of yellow fever. He was immediately given a hypodermic of morphia and atropia and one-half teaspoonful of ehlorodyne every half hour until he became quiet. Under these drugs the diarrhoea and vomiting ceased and he went quietly to sleep. He was then given a mild course of mercurials with quinine, turpentine and as a diuretic later, the bitartrate of potash with lemon juice. The next evening at six o'clock he was rational with a temperature of 103 but obstinate nausea; hemorrhage had about ceased. I then turned him over to a physician from Arkansas who had some experience in the treatment of the disease, but he died two days later. Do not know just what treatment was continued.

Case 6. Two weeks later another young man, a neighbor to the last one mentioned, and the son of a railroad contractor, was taken in about the same manner. I first saw him at two o'clock P. M. and met a priest coming out of the house who had just administered the last sacraments to the patient, as he was supposed to be dying, the parents never having seen anything of the kind.

He had passed about two gallons of dark tarry looking blood. He was totally un-



conscious, had a pulse of 145, temperature of  $105\frac{1}{2}$ , head hot and feet and hands icy cold. His teeth were pried open and 40 grains of calomel placed dry on the tongue and washed down with water, and all the epsom salts at the same time that we could get him to swallow. Ice was applied to the head and over the region of the bladder, his feet were wrapped in hot blankets and large injections of soap and warm water made. During the night his bowels moved freely, he regained consciousness and the next evening, aside from his intensely yellow color, he looked to be doing as well as if he had only had a common ague. His later treatment was quinine, iron, strychnia and arsenic and he made a complete recovery.

In his case, no quinine was given until after evacuation of the bowels and the return of consciousness.

Case 7. A week later a young married man, neighbor to the last two, was taken with symptoms of a congestive chill accompanied by profuse bloody urine. When seen six hours after, his temperature was  $105\frac{3}{4}$ , pulse 144 and semi-conscious and the skin had already assumed a very yellow cast, the color was not an orange yellow but of a sickly greenish hue. He was given twenty grains of calomel, three doses, one hour apart and four tablespoonfuls of epsom salts, and one drachm of spirits of turpentine every three hours, no injections were used. The next day his temperature recorded 102, pulse 120. There was very obstinate nausea and the hemorrhage though less, still continued. Gallic acid was added to the treatment and lime water with solution of muriate of cocaine given for nausea. The hemorrhage continued for three days gradually growing less as the other symptoms abated. Twelve hours after the beginning of the attack he was put on quinine 5 grain doses every three hours with dover powder in capsule and hydrastine. This treatment continued for three days. He made slow but complete recovery and has not had another attack, now over three years since.

Case 8. September, 1900, a school teacher, male, aged 40 years was attacked with

a congestive chill followed by active hemorrhage from the kidneys. I did not see him until the next day but he was treated the night previous with calomel purgation and large doses of quinine. At the time I was called I found his temperature 105, small very weak pulse and dark bilious discharges from the bowels, and large quantities of bloody urine were passed at intervals of one hour. He was intensely jaundiced. He was put on a mild course of mercurials, quinine, turpentine and tonics. After two days the hemorrhage had ceased entirely, the temperature was reduced to 101 and convalescence seemed fairly well established, but from this time on he sank into a low typhoid state, refusing all nourishment and died on the 18th day of his illness. He lived eight miles from me and I think needed more medical attention than he was able to secure.

Case 9. October, 1900, a young lady aged 18 years, had been having chills every day for a week. She was suddenly seized with an alarming hemorrhage from the kidneys seen a few hours later she was totally unconscious, ice cold extremities, temperature 106, no pulse perceptible. Ice was applied to the head, hot smoothing irons to her feet and a hypodermic of quinine, bisulphate and morphia given, also dry on the tongue and washed down with water, 20 grains of calomel and all the epsom salts she would swallow. This dose was repeated twice, three hours after injections per rectum caused discharges resembling tar at first, as soon as purgation was established her symptoms began to rapidly abate though there was intermittent hemorrhage for four or five days and convalescence was quite slow. After the sixth day her skin had cleared of the jaundice and her appetite had returned sufficiently to relish nourishment. I discontinued my visits on the eighth day as no longer necessary. On the tenth day she had another chill and a violent hemorrhage and died before medical help could be obtained. This case shows the proneness of the disease to return and the importance of continuing active treatment until all danger is passed.

Case 10. October, 1900, a young lady 16 years of age, had been having light chills for a month but being willful and allowed her own way, had refused to take any kind of medicine. She was taken with a chill in the morning and when seen at five o'clock P. M. had a temperature of 106, no perceptible pulse and was entirely unconscious. Ice was immediately applied to the head, 20 grains of calomel were given dry on the tongue by prying open the teeth, which dose was repeated in two hours with epsom salts and injection per rectum with warm solution; cold sponge baths were used on the surface of the body and hypodermics of quinine and morphia. The next morning she was better but at 5:00 P. M. she had a temperature of 105 and was still unconscious, with intense yellow color, a moderate hemorrhage had continued that was voided unconsciously with the urine from the beginning of the attack.

Ice was then applied over the region of the bladder and small doses of calomel combined with quinine and dover powder were prescribed, and ten drops of spirits of turpentine every three hours. The next day her temperature was 102 and pulse 98, and she made a rapid and complete recovery from that time. She was kept on quinine and arsenic and iron for one month.

The peculiarity of this case was the resemblance to acute meningitis as a complication and the length of time the patient was unconscious.

#### THE TECHNIQUE AND POSSIBILITIES OF ENDOVESICAL OPERATIVE PROCEDURES.\*

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Bottini operation and the catheterization of the ureters have been extensively discussed in the past few years. Strictly speaking, these procedures do not belong to the class of operations under consideration, and for this reason I will not discuss them,

but will confine this paper to those operative interferences which are performed inside the bladder, under the guidance of the eye, without any previous cutting operation, which is done for making the interior of the bladder accessible. In other words, operations which can be performed with the aid of instruments, which allow of the inspection of the affected areas of the bladder wall, and at the same time admit of the introduction of mechanical appliances which are used for the different operative procedures. These systems of instruments are called operative cystoscopes. Three distinct types of instruments are distinguished from each other.

Not to go into detail, but simply to mention their important points, and thus show their differences, it will be necessary to enumerate:

1. Nitze operative cystoscope. Here the lamp, prism, and window are on the concave surface of the beak. In front of the space between the lamp and the window the operative appliances are placed; in fact, the operative appliance carries in its hollow shaft the optical apparatus. The latter is movable so that the operative appliance can be brought to different distances and positions from the cystoscope part. These mechanical appliances are galvanocautic snare, cautery, small forceps, and lithotriptic forceps.

2. Casper operative cystoscope differs from the Nitze cystoscope in that the lamp, window, and prism are on the same plane, so that the whole optical apparatus is straight. The operative part is practically similar to the Nitze.

Both of these cystoscopes compel the operator to work under indirect vision.

3. Kolischer operative cystoscope. With this cystoscope the operator works under direct vision. The lamp and window are situated on the convexity of the break. To the under part of the cystoscope is attached a canal, through which the different instruments are introduced into the viscus. Their working end appears just below and in front of the window.

Considering the merits and demerits of these types, it may be stated that the beak

\* Read at the 52d Annual Meeting, Quincy, May 21, 1902.

of the Nitze instrument is somewhat bulky and clumsy, because in the beak the operative appliance and lamp are in contact, and must be introduced together. This is avoided in the Casper instrument, as the mechanical appliance is first independently introduced; furthermore, the canal of this part is wide enough to allow of thorough flushing of the bladder between the operative stages. On the other hand, the Nitze instrument is more simple, so far as its mechanical settings are concerned. Both instruments have the drawback that the operative beak covers, to a great extent, the field of operation. It has to be admitted that these two types, by permitting of the use of powerful instruments, allow of very energetic and extensive procedures.

The Kolischer cystoscope has the advantage of direct view, and that, in consequence of its construction, the working end of the mechanical appliances does not interfere with the clear view of the field of operation. Another advantage is to be found in the variety of instruments. While this instrument also allows the use of both galvanocautic snare and cautery, it is the only operative cystoscope which permits of the use of curettes, scissors, forceps used for picking up and removing small foreign bodies. But in order to keep the circumference within reasonable limits, it has but a small lumen, so that the usefulness of this instrument is somewhat limited by the small dimensions of the mechanical appliances.

I refrain from giving a minute description of the details of construction, which can be more readily understood by examining the instruments I wish to demonstrate.

In passing, it is best to mention that Mirabeau and Latzko constructed small appliances which can be introduced into the bladder independently of the cystoscope, and used under the control of the cystoscope. The limited usefulness of these devices is further reduced by the fact that they are only to be used in the female bladder. The same holds good of the Kelly instruments, which do not approach the perfection of the modern cystoscope.

An important question is the one of anesthetics, because a large number of individuals having bladder affections have also kidney diseases, and for this reason it is best to avoid general anesthetics, if it is possible.

It is a fact that most of these endovesical operations can be done under a carefully given local anesthetic. The correct application of a local anesthetic is a necessity. It is best to state at once the great danger of cocaineization of the bladder. As a local anesthetic, a highly concentrated antipyrin solution is to be recommended. It must not be forgotten that it requires ten minutes or even longer until antipyrin gives the desired effect, hence must be done at the proper time. The urethra should be anesthetized by cocaineization. While it is easy to do this within the pendulous urethra, it is best to apply cocaine into the posterior urethra with the Ultzman capillary catheter. After injecting along the entire urethra, the external urethral orifice is held fast to prevent the escape of the cocaine solution, and the entire urethra is massaged, so as to bring the solution into intimate contact with the mucous membrane of the entire urethra. The disagreeable sensations in the prostatic urethra, caused by the stretching of the deeper layers, cannot be overcome by the superficial cocaine anesthesia, but must be overcome with a morphine and atropine rectal suppository.

Previous to any operative step, it is advisable to have the bladder in as good a condition as it is possible to bring it with the usual irrigations, instillations, and internal medications. This procedure not only makes the bladder less sensitive, but also brings the localized centers of the pathological changes into prominence.

One of the most frequent indications for this method of treatment is the stubborn cases of cystitis. Under this is comprised not only the inflammation of large areas, but also small localized inflammations, as fissures, ulcerations, and remnants of cystitis, where the adjacent parts are free from pathological changes. Granulating cystitis is not an uncommon condition, and I wish to state most emphatically that these cases do not



respond to the ordinary treatment, but require surgical intervention. The method of procedure is to remove these granulations by curettement, and the method of choice is with the aid of the operative cystoscope. The subsequent hemorrhage is, as a rule, exceedingly slight. If of any severity, nitrate of silver irrigations will cause it to subside. It is my routine to inject, and to leave in, iodoform emulsion after such curettage, on account of the antiseptic and soothing effect.

Fissures which, if located in the bladder neck, cause very annoying symptoms can readily be healed with a single treatment consisting of an energetic cauterization.

A very important chapter to vesical diseases is the ulcer which follows a gonorrheal cystitis. The frequency of these and the importance of their treatment have become more recognized since systematic cystoscopy has been practiced amongst genito-urinary surgeons. The coating and the granulations which cover it must be thoroughly curetted, and prompt cure follows. It has become recognized that patients of this class can be treated for years without any results, and one single treatment with the operative cystoscope will cure these individuals.

The standpoint of the endovesical operator toward tumors of the bladder should be carefully discussed. Nitze claims that even malignant tumors ought to be operated with the operative cystoscope, pointing out that definite results even after suprapubic cystotomy and extensive resection are far from satisfactory, and that even large malignant tumors can be removed by the galvanocaustic snare, down to their bases. This standpoint is certainly not approved of by the large majority of surgeons. Under our present view malignant tumors will always call for radical operations after cystotomy. It must be mentioned, however, that if these cases are beyond operation, or refuse such a step, an endovesical cauterization often gives great relief, especially after necrosis has set in. This interference can be repeated, if necessary. I think the proper limitation for the operative cystoscope in cases of tumors is furnished by the following points: The tumor should show no

signs of malignancy; it should not be so large as to interfere with the ease of manipulating the cystoscope; it ought to be pedunculated, although it has to be admitted that even tumors with a large base can be removed, in sections with the operative cystoscopes. It is remarkable how large pieces can be removed by the evacuator, by first cutting them with cystoscopic scissors. There are benign tumors which become encrusted to such an extent that they cannot be operated with the operative cystoscope, for they are too hard, but must be removed by resection of the bladder wall.

Nodular varicosities of the superficial veins, which give rise occasionally to severe hemorrhages, are easily removed by cauterization with the galvanocautery.

Small foreign bodies and immigrated ligatures, needles, and hairpins have been repeatedly removed by means of the operative cystoscope. Foreign bodies of some considerable size should not be thus removed, on account of the unnecessary traumatism.

The operative cystoscope plays an important role in the after-control of litholapaxy. The cystoscope makes possible the minute and exact supervision of the bladder, and the small lithotriptor or forceps of the operative cystoscope is a reliable means of crushing small splinters and removing them. The latter procedures are more important if the sharp splinters become embedded in the bladder wall. This condition is very dangerous, because of the imminent possibility of perforation and suppuration, while even a powerful pump will not remove them.

Although I have given but a short sketch of the more important operative interferences, I hope it has been of sufficient detail to impress all with the advantages of these procedures. I have attempted to give the fairly exact limitations, and have not been too enthusiastic in advocating its general adoption.

#### Discussion.

**Jacob Frank** of Chicago: Mr. President—I have been much interested in Dr. Schmidt's paper in regard to the use of the cystoscope. He has given us the bright side of the cystoscope, but it has also its bad side. Of course, this instrument in the hands of a specialist, who uses it daily, is more useful in his hands than it would be in the hands of a general practitioner. I will say this much, that it is a good

instrument and ought to be a part of the surgeon's armamentarium for diagnostic purposes. But it is not a good thing to use in every case. For instance, the anterior part of the bladder cannot be manipulated with any of these cystoscopes, especially with the Kolischer cystoscope, which, I believe, is a modification of the Nitze cystoscope. The Kolischer cystoscope reflects the light from the operator, and after it is introduced into the bladder it can be seen that the anterior part of the bladder cannot be brought under the direct view of the eye, and any of these straight cystoscopes will not answer the purpose, so far as the anterior portion of the bladder is concerned. With the Nitze and Casper cystoscopes, observations cannot be made of the entire trouble. The same difficulty arises, again, in removing tumors or in cutting the anterior part of the bladder. Another objection to the operative cystoscope is that when one draws the little blade it covers the field of the prism, which shuts off the light. For minor operative procedures in the female, I do not think there is anything that can take the place of the Kelly cystoscope.

**Dr. Schmidt** (closing the discussion): I did not have much to say in regard to the Kelly instrument. The most of my work has been confined to the male bladder. Of course, the Kelly instrument can be used in male cases, but from the standpoint of work, the instruments I have mentioned can be used with greater ease on the part of the operator and with less trouble to the patient.

### THE ADOLESCENT GIRL.\*

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Many of the individual constituent parts of the body are capable of reproduction. They can give rise to parts like themselves or they are capable of regeneration, i. e. their places can be taken by new parts more or less closely resembling themselves. The elementary tissues undergo, during life, a very large amount of regeneration—thus the old epithelium scales which fall away from the surface of the body are succeeded by new scales from the underlying layers of the epidermis; old blood corpuscles give place to new ones, worn out muscles or those which have failed from disease are renewed by the accession of fresh fibres; divided nerves grow again; broken bones are united; connective tissue seems to disappear and appear again almost without limit, and new secreting cells take the place of old ones which are cast off.

\* Read before Woman's Club of Bloomington.

The regeneration by substitution of molecules which is the basis of all life, is accompanied by a regeneration by substitution of mass.

In the higher animals the reproduction of the whole individual can be effected in no other way than by the process of sexual generation.

We have the different phases of life. Dentition marks the first epoch of life. A characteristic of the nervous system in childhood, the result probably of the more active metabolism of the body, is the necessity for long or frequent and deep slumber. Shortly after the conclusion of the permanent dentition, the occurrence of puberty marks the beginning of a new phase of life. Adolescence means youth or the period between puberty and maturity and in the girl is usually reckoned as extending between the ages of twelve and twenty-one years.

A study of physiology teaches us that all the so called vital organs, which means those having to do with the continuance of individual life, are functionally active from birth until death, but the group of organs functionated for race continuance, remain small and inactive throughout infancy and childhood.

During these years sex distinction is not marked except in the character of the sports; the impress of the latent sperm cell manifesting itself in greater aggressiveness and egoism in the boy, while the dormant germ cell very early sets the maternal stamp upon the brow of the tiny maiden in the love and care for dolls.

But as the twelfth or fourteenth year approaches there is a marked change in the appearance and characteristics of both the boy and the girl, so great a change that some one has said "We are born twice, once to exist—again to live."

When menstruation appears the girl at once becomes a woman. The girl's pelvis and abdomen enlarges, but the whole frame remains more slender, the muscles and joints are less prominent, the limbs more rounded and tapering than in the male. Locally both external and internal organs undergo a considerable and rapid enlarge-

ment, the mammae enlarge, the ovarian vesicles become dilated and there is established a periodical discharge of one or more ova accompanied by a sanguineous fluid from the cavity of the uterus. These changes so varied and extraordinary often occur within a very short space of time and as they are liable to serious derangement in the girl, great care should be taken to secure for the individual the most favorable conditions until they are successfully effected.

Puberty is literally a physiological second birth by which a new and changed creature is given life, for not only is there a changed physical appearance but the mind, the heart, the soul, all are affected by the subtle something which comes from the growth and development of those organs whose function it is to cradle the race.

Puberty occurs earlier in girls than in boys and earlier among the inferior races, like the Africans, than among civilized nations. Habits of vigorous physical exercise tend to delay puberty. For this reason, together with others, country boys and girls generally mature later than those living in the city by several months. Anything that tends to excite the emotions hastens puberty. The excitement of city life, parties, balls, theatres, even competition of students in school and the various causes of excitement to the nervous system, which occurs in city life and sensational novel reading and a sedentary luxurious life, have a tendency to hasten the change which awakens sexual activities of the system into life.

Hence these influences cannot but be considered prejudicial to the best interests of the girl, mentally, morally and physically since it is in every way desirable that a change which arouses the passions and gives to them greater intensity, shall be delayed rather than hastened.

At this period there is a greater influx of strange sensations—the brain aroused by new stimuli is increased in activity.

The adolescent mind is filled with hopes, dreams, temptations, passions and new ideas. There is a great increase of vitality and energy as is manifested by the rapid growth and it is hygienic for the more strictly physical to take the lead at this time, just as

in childhood physical development should take precedence since undue mental stimulation from too difficult studies causes arrest of development. So at adolescence the advent of puberty should not be hastened nor should a mental storm stress period be precipitated by disturbing philosophic and religious instruction.

It is evident that there is a great evolution of energy that must find expression in some way. It also is clear that at this period education must no longer be mere acquirement. It is the time for manual training, for laboratory work and sports. Girls have suffered more than boys by neglect of active education and it is not strange that so many girls grow up into suffering womanhood, when we consider the manner in which this physical second birth takes place. It is rare indeed that intelligent suggestion or wise words of counsel tell her of the importance of the period of maturity.

Usually if she thinks of this period at all it is simply as an incident, not as an epoch which is to stamp her whole future earthly existence with weal or woe.

The importance of this period cannot be overestimated and when this becomes a generally recognized fact we may begin to look for a healthier, happier, more beautiful womanhood and not before for it is during this period that the future health of the woman is largely made or marred.

It would seem therefore to be of the most vital importance that a maturing girl be given such care and training as would insure her proper physical development, without which her life cannot be a success in the fullest sense of the word. The parent and physician cannot fail to have noticed the great number of unhealthy girls after the age of pubescence.

During the period of infancy and childhood the boy and girl are liable to the same class of physical disorders and with an equality of heredity and environment the girl is not more susceptible to the diseases of children than the boy. After the period of puberty is reached there is a marked difference in the comparative health of the maturing boy and girl. That this differ-



ence of health rate is dependent wholly on difference of sex is doubtful.

As puberty approaches the character of sports and amusements of the two sexes become more and more diverse. For many times fond but foolish mothers in their efforts to have their daughters form habits which indicate good breeding; repress the childish desire for activity and instead of permitting romping games in the open air after school hours, the girls are encouraged to sit quietly with their dolls, books or music while their irrepressible brothers exercise their muscles and improve their circulation by out of door games and occupation. Ignorance of bodily construction and function also permits many indiscretions which indirectly but certainly invite the penalty of violated law. Ignorance permits many young girls to needlessly expose themselves to changes in the weather, insufficient or damp clothing is worn and the feet allowed to remain cold or damp at those times in the month when the greatest care is necessary to prevent physiological congestion of pelvic organs and thus the foundation of future ill health is speedily and silently laid. There is no knowledge which is so necessary a part of her stock in trade as that which will help her to become a healthy, well developed woman and keep her so.

Education is a causative factor in the prevalence of ill health among girls. It is a physiological law that the growth of an organ is dependent on its blood and nerve supply. It is also a physiological law that the organ or organs in most active and constant use demand and get a greater nerve and blood supply than the inactive or passive ones. At the approach of puberty therefore the maturing uterus and ovaries require more attention from the circulatory and nervous system than previous to this time else growth cannot be accomplished.

But our modern system of education begins to impose the necessity of greater and more constant mental application between the years of twelve and eighteen, and what is the result physically? The brain because of its continual use necessarily calls

for a surplus of blood while the inactive but feebly maturing pelvic organs are left with but a minimum for their development. In short they are starved for want of proper nourishment and cannot grow as nature intended and we have non-development. These organs are dwarfed and inactive and consequently complain in the language of pain and distress for another physiological law teaches us that the undeveloped organ is much more liable to disease than one in which development is complete.

It is not difficult to understand therefore how ignorance of physical law coupled with the overcramping methods of education make possible the wrecking of so many beautiful physiques. The government has made the acquirement of a so called common school education compulsory with all children over a certain age and on all sides the greed for knowledge is only exceeded by the universal greed for gain. The purpose of an education is simply a process of mental drill and discipline which will enable a student to broaden his life's horizon and pick up applied knowledge later on—or it is for the purpose of acquiring such knowledge as will enable him to not only appreciate the good, the true, the beautiful in life but to become a useful, helpful member of the native family. Yet only a small per cent of the children who are to be the future men and women, will ever be able to obtain more educational opportunities than the public schools afford. Hence it is upon the public school system even more than upon the higher centers of learning that the weight of responsibility rests in directing both mind and body into useful, healthful channels. So far as our present methods of education are concerned with the mental and physical development of maturing girls, it can be truthfully said that she has the opportunity of becoming more or less familiar with almost any subject except herself and those things which are to occupy a large share of her adult life. She has excellent opportunities for learning about the formation, habits and peculiarities of flowers, beetles, birds and animals, but when it comes to any scientific instruc-

tion regarding her own formative function and care, only the most limited and carefully perused information is usually available. When her high school or college course is ended she, in many cases lacks a physique robust enough to become a teacher or home maker.

We all know too many cases where the young graduate dies before she has fairly rested from her long hard pull of final examinations. No false modesty should be allowed to debar any pubescent mind from acquiring the same dignified, scientific, classified instruction regarding body function and the laws of life—as is now considered proper regarding the lower animals and allied subjects.

The chemistry of food stuffs with a knowledge of their proper combination or a thorough understanding of house sanitation, heating, ventilation, sewerage, and cleanliness is of more importance than a few months training in inorganic chemistry or a knowledge of some dead language.

There are many other causes of ill health of which I can mention a few. Dress is an important factor in the cause of disease.

Normal breathing of woman is like that of man—abdominal. Waist constriction changes the type of breathing to thoracic.

Abdominal respiration is essential to woman's health. Clothing must be worn that does not restrict it. All women who wear corsets and tight waist bands breathe with a well marked sternal movement. The costal or thoracic respiration is abnormal in women as it is in man. Kelly has confirmed the observation among various Indian tribes and among Chinese women, agricultural women and English pit brow lassies; and civilized women who have always been loosely clothed about the waist show the same type.

Women asleep breathe like men, and male and female animals alike and the very argument that chest breathing is normal to woman because it is necessary during gestation falls to the ground when it is shown that even late in pregnancy abdominal respiratory movements predominate over thoracic movements.

The agent most active in abdominal breathing, the diaphragm, is a muscle that can be developed like any other muscle so that long distance runners in the quiescent condition have least costal breathing of all men. The constant to and fro motion of the pelvic organs is essential to their health. With each movement of the diaphragm the structures of the pelvic floor and the organs above it are carried downwards, one-tenth to one-third of an inch and up again in the case of women who have worn clothing loose about the waist. Alternating pressure and relaxation secure free flow through the large venous plexuses and lymphatics. Alternating traction and relaxation develops the muscular bundles of the uterine ligaments and of the muscular pelvic floor.

The alternate stretching and slacking strengthens elastic supports. As in any other part of the body, exercise is needed, rest and motion in right proportion and the organs themselves need it as much as their supports and blood vessels do.

With each inspiration the descent of the diaphragm increases the pressure in the abdominal cavity and lessens that in the chest, blood is squeezed out of the pelvic and portal veins, at the same time sucked up above the diaphragm.

Therefore dress that cripples the diaphragm, slows pelvic circulation. The valveless ovarian veins empty in the area of greatest corset pressure, giving a long and perpendicular column of blood to be dammed back.

When the corset is worn, little or no motion can occur because all structures in the true pelvis are carried down by constant pressure to the utmost of their ability, to move in that direction. The uterus cannot make its excursion of a tenth to a third of an inch with each respiration. The clothing must not displace the pelvic organs. The pressure from a tight corset or a loose corset with the wearer in a bent position bulges the pelvic floor downward to the utmost limit of its capacity to yield.

The uterus is correspondingly depressed. Consequently all its supports are stretched and kept tense for many hours daily while any exertion or stooping strains these taut

structures still farther. In consequence we have pelvic inflammation and misplacements. Activity and exercise are essential to health. Clothing must be loose, light and well hung not to hamper muscular action.

The house habits of girls, the lack of participation in active sports, the imperfect muscular development and the sluggish peristalsis have an important effect in the ordinary methods of dress.

"Look at a lot of girls on the way to the gymnasium," said a Vassar teacher. "They drag along, they have no spirit or spring in them, they are in their ordinary clothes. Look at the same set coming on to the gymnasium floor in their light toggery—they skip and dance and run in the liberty of their unrestrained and untrammelled motion—they are different beings."

To remove corsets and leave the girl to the constriction of her waist bands, and heavy skirts hanging on the abdomen is of little use. In college where girls are readily reformed, a physical culture teacher says the trouble lies principally with the mothers. "Tell my girls that tight lacing will hurt their complexions," said a school principal, "and you have a lever." It is an important fact that in the early periods of the history of the human race there were no essential points of difference in the dress of the two sexes, except perhaps in the way of wearing the hair. Roman men and women for instance, wore pretty nearly the same kind of external garments. A plate in *Planches History of Costume* represents a group of Anglo-Saxon men and women of the tenth century, and it is difficult if not impossible to tell which of the figures represent men and which women.

The traditional fig leaf was the same for both sexes and from it were evolved skirts that varied but little in shape and general appearance, whether they concealed the nakedness of a man or that of a woman. The differences that now exist have mainly been caused by the revolt of man from the inconvenience of long skirts, and the assumption by him of a separate covering for each leg. What he has gained in the facility with which he can run, leap, climb trees, straddle a horse, row a boat and do many

other things that his occupation requires of him, he had certainly lost in grace and elegance. Trousers are of oriental origin and in the form of breeches were worn by the ancient Gauls and Britons.

They went out of fashion however soon after the occupation by the Romans and the gown acquired its place for both sexes.

Constipation is a prevalent disorder among girls. It is the result of improper diet and sedentary habits but is quite as frequently the effect of neglecting to evacuate the bowels at a regular hour each day, which is essential to proper and regular action. Constipation gives rise to congestion of the pelvic organs and to displacements by violent straining. Neglect to care properly for themselves at the menstrual period either through carelessness or ignorance of the consequences is probably one of the causes of uterine or ovarian disorders of the adolescent girl.

I have known of girls who complained of sick headache and lack of appetite and yet are mincing most of the time between meals, at candy, soda water and all sorts of confection. Their digestion is destroyed. It is no wonder they have no appetite for a substantial meal. The digestive organs like all other organs must have a period of rest.

The most beautiful face is marred when disease begins its ravages on the body. The most beautiful character is as speedily spoiled by the touch of moral disease. The face is the mirror of the mind. The character is written as plainly on the face as the face can be pictured by an artist on canvas. To be more explicit, the girl who disregards the laws of health, who eats bad food, eats at all hours or at unreasonable hours, sits up late at night, and indulges in the usual means of dissipation and neglects to comply with the requirements of health may be certain that sooner or later at no distant day she will become as non-attractive and homely as she can wish not to be. The cheeks may be ever so plump and rosy but they will certainly lose their freshness and become hollow and thin.

All little girls want to be beautiful. Girls in general care much more for their



appearance than boys. They have finer tastes and greater love for whatever is lovely and beautiful. A pure, innocent, beautiful little girl is the most lovely of all God's creatures. Health is essential to beauty. In fact if we consider goodness a state of moral health, the health is the one great requisite of beauty.

Health is attained and preserved by the observance of those natural laws which the Creator has appointed for the government of our bodies.

### HYDRO AND ELECTRO THERAPY IN THE TREATMENT OF DISEASES OF THE ALIMENTARY TRACT.\*

BY E. M. ECKARD, M. D., B. S., PEORIA.

In these days when cults and pathies have sought to take away prestige from the Regular School of Medicine, we are apt to shun those means of treatment which these people use to gain their nefarious ends. We are too fearful of adding our endorsement to the remedies which are used with such abandon and grossness as to bring them into illrepute. And yet we must admit an element of truth in all these pretensions else they could not live. Because an imposter tells the people he can diagnose all diseases by means of the X-Ray shall we discard it? Because another says that Sulphur water will cure Syphilitic and other blood diseases shall we discard the use of Medicated waters? Again the people have been forced in self protection to demand freedom from continual drugging. They are looking for other and simpler means of cure and we should be the ones to apply those means not others ill-prepared. Many of those chronic cases which have been to numbers of good physicians finally land at a Sanatorium as a final resource, and are greatly benefitted by means of properly administered Hydro and Electro therapy in connection with diet and proper exercise. It is because of this that I am led to talk on this subject.

There are many diseases of the Alimentary tract to which Hydro and Electro

therapy are applicable, among which are Acute and chronic constipation, bowel obstruction, Auto-intoxication from absorption of intestinal toxins, diarrhoea, dysentery: Dilatation and neuralgia of the stomach, chronic Gastritis, gastralgia as well as the various neuroses such as visible peristalsis, flatulenee, enteralgia, and intestinal neurasthenia.

The use of electricity in the treatment of intestinal diseases is from its very nature limited, and experiments have not been very profuse along that line. That intestinal movements can be produced by the electric current is easily proven by observation of the effects in subjects with thin walled abdomen. There has been some argument also as to the proper current, some advocating the galvanic some the faradic and yet others the mixed current. There seems no doubt that both currents are useful but the faradic seems to me to be most frequently indicated. The two alternated are best used to create peristalsis. In regard to the galvanic current, experiments by Schillbach indicate local waves of contraction at the Cathodal end and peristaltic waves of contraction at the anodal end. I have several times seen immediate movements of the bowel follow the application of the faradic current one electrode on the abdomen, the other in the bowel. I at first thought this due to the irritation of the electrode, but as the same result was not obtained without the current I concluded the electricity was responsible. I should add that in a number of cases this means failed to create sufficient peristalsis to cause a movement without the softening influence of the douche. In cases of impaction the abdominal sponge should be about two inches wide and should be applied with respect to the anatomy of the tract and at a point above the accumulation; while the internal electrode which is shaped like a rectal tube having a spiral connection leading through the tube and emerging as a smooth, rounded point at the distal end. This may also be perforated and a stream of water allowed to play through it during the treatment which should last about 15 minutes. The current should be applied strongly enough to produce contractions of

\* Read at the 52d Annual Meeting, Quincy, May 21, 1902.

the abdominal muscles. In applying Galvanism, the anode is placed by means of a broad sponge on the abdomen and the cathode inserted in the rectum; the treatment should be of about ten minutes duration and of strength about 20 milliamperes. The results of the treatment are not immediate but a movement of the bowels takes place in from two to four hours. The cases on which I have used this treatment were chronics of months or years standing and I want to say that in addition to the mechanical effect the mental effect is also commendable.

Electricity is of great value in sensory and motor neurotic disturbances of the tract, and in these neuroses the Static breeze given daily for 15 to 30 minutes proves a valuable adjuvant, relieving the nervous tension and causing the patient to "let loose of the bowels" if you please.

In dilatation of the Stomach, the introduction of an electrode into the stomach and the application of galvanism has been highly commended. It is easily accomplished in patients who have become used to swallowing the stomach tube. Several kinds of stomach electrodes have been devised the best and most easily swallowed being one devised by Einhorn upon somewhat the principal of the stomach bucket being olive shaped, of perforated hard rubber and containing a metal button. This is attached firmly to an insulated wire. The electrode being much like a large capsule is not difficult to swallow. A quantity of water is first swallowed, contractions being brought about through electrization of the water. It is very doubtful if the external application of either current over the abdomen has more than a slight effect upon the contraction of the stomach or bowel, but used internally it not only increases peristalsis but causes a modification of the flow of gastric juice. Both of these facts have been sufficiently proven by many experiments both upon men and animals. The method of application of galvanism which we have followed is placing the negative pole within the stomach and a medium sized sponge externally at different points over the stomach for periods varying from one to three minutes giving

the last two minutes of a ten min. seance above the seventh dorsal vertebra. In Gastro-faradization use a large sponge and let the general movement be from left to right, the current being of sufficient strength to cause contraction of the abdominal muscles but not strong enough to produce pain.

Einhorn sums up the physiological and therapeutical action of electrization of the stomach as follows:

1. Direct faradization of the organ increases gastric secretion during and for a short period after treatment.

2. Direct galvanization of the stomach negative pole within usually decreases secretion.

Therapeutically direct gastro electrization is potent in chronic diseases of the stomach non-malignant in character. Useful in dilatation not complicated by obstruction. In relaxation of the cardia or pylorus, the former being disagreeable on account of eructation of gas, is well treated by electrization direct. It is the sovereign remedy in gastralgias no matter what their cause, favorably affecting the heart as well.

In intestinal disorders Hydrotherapy is of even more value than electricity. The simple drinking of large quantities of water aids much to clear the intestine of obnoxious material, mucous and bacteria. Various mineral waters may be selected from those at our command but oftentimes pure water of any kind will answer all purposes if persisted in doing fully as well as that from the various natural springs. There are some waters which have a tendency to diminish secretion, but most have an opposite effect, increasing secretion and peristalsis. Other hydrotherapeutic measures are moist applications, cold to stimulate and hot for sedative effect. Combined with electricity water is a most potent agent. Where there are neurotic conditions governing the intestinal disturbance, the use of baths and douches are of extreme value; especially is intestinal neurasthenia benefitted by the combined treatment. In treating habitual constipation the use of cold enemata with cold local application to the abdomen will aid peristalsis wonderfully. Alternating hot

and cold douches to the abdomen will have an even more pronounced effect.

Lavage of the stomach was first rationally used by Kussmaul in 1867.

You are all familiar with the usual manner of performing this treatment, but the most satisfactory manner of lavage is to use a graduated glass irrigator which may be hung on the wall. The irrigator is attached to a tube having a glass "V" connecting the stomach tube to the inflow and an outlet tube. By means of snaps the washing out process becomes very simple and satisfactory. Einhorn has devised a stomach spray which he claims is valuable in applying medicines of a toxic or irritant character besides washing the stomach thoroughly. Lavage is contra-indicated where there is hemorrhage or ulcer of the stomach.

It should be borne in mind that organic disease of the intestines often has for its origin a neurosis just as cystitis may develop from a paralysis. Neuroses of the intestine may result in or exhibit motor, sensory or secretory disturbance. In cases of functional enteroplasm and protoplasm it is imperative that cold applications be made externally and cold douches be given internally in addition to the other means used to allay the condition. In the same manner the general nerve toner should be built up with tonics of which balneotherapy is one of the most efficient and doubly valuable when aided by electricity.

Of course hydro and electro therapy should not be used to the exclusion of drugs and other valuable remedies such as massage, mechanical movements, diet, etc., but they are the most valuable of all adjuvant agents in the treatment of the above mentioned diseases.

A large amount of literature has been written upon the value of electricity and water in the therapeutical field but most of the writings have been for purposes of advertisement of institutions and for sensational effect. A few men have given us the results of their honest efforts and have accomplished many cures. I have recorded a few cases two of which I wish to quote.

Case 1. Man aged 50 years, life insurance officer. Syphilis; 20 years before attacked

with all symptoms pointing to impaction of bowel. All sorts of purges and injections of water, oliveoil, castor oil, soapsuds, etc., first tried, then high rectal injections with no result. After 12 hours vain efforts inserted electrode with douch and gave 15 mins. of electricity beginning above and leading down to the obstruction; result in movement of the faecal mass down to the rectum where it was easily handled.

Case 2. Man aged 45, great eater and drinker, symptoms of dyspepsia, patient ravenously hungry at times. Losing weight. Examination showed digestive fluids diminished. Fermentation taking place. Constipation. Scanty urine. Presented a large abdomen and had a dilated stomach. Treatment was lavage, leaving some water in the stomach and introducing Einhorn's deglutible electrode. Treatment; daily use of faradic current for 15 mins. In addition gave a digestant after meals and as a laxative left half pint of glycerine water in bowel over night. Treatment lasted three weeks and resulted in a complete cure as far as the symptoms were concerned. I am perfectly satisfied that there is a wide field of usefulness for electricity in these conditions and believe their use should be more frequently resorted to.

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#### CONCERNING A NEW SERIES OF SYNTHETIC SALTS; THE NUCLEIDS OF IRON, COPPER, MERCURY AND SILVER.\*

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Compounds of Mercury, Silver, Copper and Iron have been employed since the earliest times, in Medicine, but our information as to their effects on diseased conditions in the human body has been decidedly hazy. Therapy, unless it be of quite recent institution, is empirical and founded on conjecture; but the trend of modern medicine is in the direction of rational therapeutics,

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\*Read at Meeting of the Chicago Medical Society May 7, 1902, and at the Meeting of the Illinois State Medical Society, Quincy, May 22, 1902.



that is, in the employment of means suggested by the disease resisting powers of the body, and to prescribe so as to not interfere with or antagonize the conservative efforts of the organism, and it is just here that synthetic chemistry is particularly useful, by imitating nature and building up in the laboratory, remedial agents similar to those constructed by the chemie processes of the system.

There is hope that chemistry will unlock the secrets of the so-called immunizing agents and show the exact nature of those valuable chemie bodies and the processes by which they enable us to combat disease.

While many of the newer remedies possess chemie properties of the most astonishing kind, careful investigation shows, also, that many have no direct therapeutic value, which is easily explained when we consider how different from natural processes of disease are the circumstances of experiment.

It has been estimated that, in the last thirty-five years, no less than four hundred so-called antiseptics or germicides have been introduced to medicine. Compounds of Mercury, Silver and Copper have found a very extended application as germicides, particularly Mercuric Chloride (Hg. Cl. 2), Silver Nitrate (Ag. No. 3), and Copper Sulphate (Cu. So. 4).

The exact action of these germicides is not understood, although it has been variously explained. It is well known, however, that they are as a rule decidedly irritating and devitalizing: these undesirable features have been explained on the ground of their chemie affinity for the tissues or for the cell constituents.

For centuries iron has been administered without a thought being given to the question of *how* it acted: the results being satisfactory, that was all the physician (and the patient) cared about.

We know that certain metallic salts will enter into chemie combination with certain proteid substances and recent investigations seem to have demonstrated that the leucocytes are the agents of absorption and transportation through the circulation of compounds of Hg., Ag., Fe., and Cu.

While the chemistry of living substances is still beyond our knowledge and blood conditions are difficult to understand, the theoretic consideration upon which these salts were manufactured was stimulated by the physiologic investigations of Schafer, Bunge, Lowit, Halliburton, Vaughn and many others, which show that the most distinctive constituent of white blood corpuscles is Nuclein.

By Nuclein is meant that constituent of the cell by virtue of which this histologic unit grows, develops and reproduces itself. Chemically the nucleins are complex proteid bodies, notable for the large amount of phosphorus which they contain in the form of Nucleinic Acid and by virtue of their Nuclein, the cells of various organs possess and manifest their individual peculiarities.<sup>1, 2.</sup>

With our present knowledge of the components of white and red blood corpuscles and of lymph corpuscles, we are justified in stating that the most important constituent of them is the complex nitrogenous body called, first by Miescher<sup>3</sup>, since it is present in all cell nuclei, Nuclein: a body which is remarkably stable and difficult to change by chemical agents<sup>4</sup>.

The leucocytes consist of 88.51 per cent. water and 11.49 per cent. solids, of which nuclein comprises 77.45 per cent<sup>5</sup>; the nuclei of pus corpuscles also consist very largely of Nuclein<sup>6</sup>.

The red marrow cells have been examined macro-chemically and found to contain high per centages of nucleo-proteids<sup>7</sup>. The red blood corpuscles have been found to possess, besides haemoglobin (86 to 94 per cent.), Nuclein in amounts ranging from 5 to 13 per cent<sup>8</sup>.

The liver<sup>9</sup>, spleen<sup>10</sup>, salivary glands<sup>11</sup>, kidneys<sup>12</sup>, lungs, testes<sup>13, 14</sup>, semen, ovaries, spermatozoa<sup>15</sup>, brain, cord and other nerve tissues<sup>16, 17</sup>, thymus<sup>18</sup>, and thyroid glands<sup>19</sup>, have all been examined chemically with the result that Nuclein has been found to be the most abundant, as well as most important proteid substance present. Wherever nature provides for the elimination of poisons or waste products of any description, there we find Nuclein present both in the

cretions and in the tissues. The only proteid that has been obtained in any quantity from the thyroid gland is a Nuclein<sup>19, 20</sup>; this observation should be of great importance in considering the administration of thyroid gland or extracts of it in certain conditions.

It may be that the administration of Nuclein or Nucleinic Acid would be attended with good results in those cases where the exhibition of the gland itself has been of use.

Among the constituents of blood plasma, Nuclein has been demonstrated, and that the germicidal action of the blood is not due to phagocytes nor to serum-albumin, but is due to the Nuclein present, furnished by the polynuclear leucocytes has been demonstrated by Vaughn and McClintock<sup>21, 22</sup>. I do not discuss the theory of phagocytosis proposed by Metschnikoff, in this connection, since I believe anyone familiar with his later writings<sup>23</sup>, will agree that they offer a satisfactory demonstration of the statements of Vaughn and others as to the role played by the multi-nuclear leucocytes. The solid matter of the colorless corpuscles originating in lymphoid structures probably consists very largely of Nuclein<sup>24</sup>. The vitality of the animal organism depends upon the integrity and functional activity of its cells: health is maintained and resistance to disease effected through the influence of the so-called "defensive proteids" of which Nuclein is the most active. That Nucleinic Acid is a powerful germicide was first shown by Vaughn, Novy and McClintock<sup>25</sup>.

The foregoing resume is sufficient grounds for the assumption that Nuclein or Nucleinic Acid occupies a much more important part in the physiology of the human body than we have been crediting it with.

Remembering these facts and theories, Schwickerath of Bonn<sup>26</sup>, conceived that it might be possible to form soluble compounds of the metals (Hg, Ag, Cu and Fe) which had been of so much value to medicine, with Nucleinic Acid, a substance common to both blood corpuscles and the vital tissues of the body, upon the assumption that such substances if possible to produce would be

more gratefully received by the human organism and act less like foreign bodies than the commoner compounds of the metals.

Nucleinic Acid can be obtained from semen, salmon sperm, blood and yeast, but the difficulty arose of obtaining quantities of the acid by processes not too complicated. While the chemie formula of acids derived from these different sources differ markedly<sup>27, 28</sup>.

Nucleinic Acid from blood— $\text{C}_{30} \text{H}_{52} \text{N}_9 \text{P}_3 \text{O}_{17}$ .

“ “ “ Salmon sperm— $\text{C}_{40} \text{H}_{94} \text{N}_{14} \text{O}_{17} (\text{P} \frac{3}{5} \text{O})_2$ .

“ “ “ yeast— $\text{C}_{40} \text{H}_{59} \text{N}_{16} \text{O}_{22} (\text{P} \frac{2}{5} \text{O})_2$ .

the physiologic reactions of these acids are practically identical and as yeast cells *Saccharomyces Cerevisiae* can be made to yield the acid more easily, this source was chosen.

When the statements of the various authors who have dealt with Nuclein are compared, it seems as though no definite substance exists to which the one name of Nuclein could be properly applied: but it is more probable that the different results of the various workers are to be attributed to the impurity of the substances on which they operated<sup>29</sup>, or the faulty technique of their experiments.

Pure Nucleinic Acid from yeast being quite soluble in water, but more so if a small amount of alkali is added to the water: a solution of the acid is prepared and freshly precipitated oxide of the particular metal under consideration is added and gradually dissolved, combining with the nucleinic acid.

If a large quantity of alcohol (in excess) is now added, a voluminous precipitate is formed which is the new chemie compound of Nucleinic Acid and Mercury, Silver, Copper or Iron, as the case may be. These new compounds contain the metals in true chemie combination<sup>30</sup>, they do not precipitate albuminous substances, are not precipitated by alkalies<sup>31</sup>, and are very slightly affected by hydrogen sulphide; are soluble in water with faintly alkaline or neutral reaction, are also soluble in glycerine, liquid petrolatum, and lanolin. They are not soluble in alcohol or ether. They are decomposed by strong acids (nitric and sulphuric) not by dilute hydrochloric acid. Their

aqueous solutions are not changed by boiling. They all have a metallic taste.

The Nucleid of Mercury contains 10 per cent. of the metal and has been named Mercuriol by Dr. Schwickerath. The Nucleid of Iron has 6 per cent. of iron and the name Ferrinol: The Nucleid of Silver contains 10 per cent of Ag and is named Nargol. Cuprol is the nucleid of Copper and contains 6 per cent. of the metal.

The chemie formulæ of these salts have not been determined and while the seeming inconsistency of not being able to demonstrate the chemie constitution of these nucleids, (when we know the valence of the metals and know the chemie constitution of the nucleinic acid), and in claiming a definite chemie constitution for them, seems at first glance to be incontrovertible, still it is easy to explain to a chemist familiar with albuminoid substances.

It is a well known fact that the slightest variation in one, of the multitude of conditions supervening in the chemie investigation of the constitution of an albuminoid body, is sufficient to modify the result obtained so that it is almost impossible to duplicate the conditions so as to produce exactly duplicate results. These are difficulties experienced by chemists constantly in their work upon albuminoid compounds.

Regarding the statement that Nargol, Mercuriol, Ferrinol and Cuprol are definite chemie compounds, I may state that this is based upon the evidence afforded by the lack of action upon these compounds of the precipitating agents commonly used to distinguish the metals.

When to a solution of Ferrinol, a solution of  $H_2S$  is added there is no immediate reaction between the two, but a dark color gradually develops which very slowly changes into black, apparently indicating decomposition: tests show that it takes a very long time to produce complete conversion of the nucleid into sulphid—the time necessary for this action being infinitely longer than where ordinary iron salts are employed.

Cuprol is not precipitated by  $H_2S$  nor does it give the characteristic blue color when treated with alkalis.

Ferrinol is not precipitated by  $NH_4$ ,  $OH$  or by  $K_4$ ,  $Fe(CN)_6$ ; this latter reagent producing only a slight blue color upon adding it to a Ferrinol solution.

When  $NaCl$ , or dilute  $HCl$ , is added to Nargol solutions there is no characteristic reaction between them, but a change takes place which (shown by repeated tests) requires about ten days for the decomposition of the silver salt. In like manner a solution of Mercuriol is very slowly decomposed by  $NaCl$  or  $HCl$ . Mercuriol requires a very long time to show any reaction with  $H_2S$ , and it is not precipitated by alkalis. The ordinary soluble salts of Mercury and Silver on the contrary are instantly precipitated by both. This remarkable behavior on the part of these nuclein combinations with their characteristic re-agents certainly affords grounds for declaring that they are joined by one chemie bond, i. e., that they are formed by a chemie reaction.

The therapeutic application of Nuclein and compounds of Nucleinic Acid is perfectly rational and supported by plenty of evidence based on clinical observation and experimental research. The theory briefly stated, is to supply the human organism directly, that which it is constantly acquiring by more circuitous processes, thus going to the root of self cure and using the laboratory for the artificial increase of the "defensive proteids" of the human body.

Practically the same theory underlies the so-called serum therapy, for while there is supposed to be an antitoxin for every toxin, yet the nucleins are presumed to be general and constitutional, not local and specific: in other words, they act as negatives to all kinds of positive displacements of the physiologic balance between health and disease.

More thought and work have been expended by physiologists in endeavoring to explain the physiologic importance and action of iron salts, than those of other metals, so we may consider the nucleid of iron to good advantage, inasmuch as the internal administration and reactions of this series of nucleides seems to be practically the same.

The essential value of the inorganic salts of the metals, to the proper nutrition of the body, does not force itself upon our at-



tention, since, as a rule, we unconsciously get a proper supply with our food (with some exceptions) without the necessity of making a deliberate selection. But they are surprisingly important in the maintenance of the normal physiologic and chemie properties of the tissues and body fluids<sup>32</sup>.

The greatest importance of iron salts lies in the fact that the continual formation of new red blood corpuscles requires a supply of iron for the synthesis of haemoglobin, in fact there is strong reason for the belief that all the iron necessary for the formation of haemoglobin is derived from Nuclein Compounds. Iron has been demonstrated in the nuclei of the white cells<sup>33</sup>.

Aporti<sup>34</sup>, found that iron, par excellence, was the metal affected in the formation of haemoglobin.

In many conditions the administration of iron according to preconceived notions retards rather than accelerates the recuperative forces. According to Osler, Cushny, and others, the tincture of iron chloride is worse than useless in erysipelas. Years ago anaemia was treated by massive doses of iron, but greatly diminished doses are the rule now.

Some physiologists deny the absorption of the chemist's iron and many believe that only a limited percentage is absorbed. Nothing definite seems known regarding the absorbable form of iron and only approximate estimates can be given as to the amounts taken up by the organism.

Some of the latest physiologic experimental workers claim that the inorganic iron follows the course of the food iron, but fail utterly to prove their case. It seems to me that the *nutrient* forces of nature or, in other words, the chemistry of nutrition must hold the secret so sought for.

That iron is absorbed by the intestinal villi and assimilated by the lymphatics, the same as any other food element, I believe to be true. The absorbing cells of the intestines take up certain parts of the intestinal contents in which they are bathed and build up from these certain materials which pass into the lymph currents: the cells of the secreting glands take up materials from

the lymph currents in which they are bathed and from these elaborate, in some manner, products which are passed into the gland as a secretion<sup>35</sup>.

That absorption and secretion are selective chemie processes and not of a purely physical nature has been proven<sup>36</sup>. The remarkable quantitative resemblance between the ash of milk and the ash of the body of the young, and the equally striking difference between the ash of milk and the ash of the maternal blood, shown by Bunge, seems to show that the inorganic salts are formed from the blood serum, not simply by osmosis, but by some selective absorptive or secretory act<sup>37</sup>.

Bunge<sup>38</sup>, and Schmiedeberg<sup>39</sup>, have found in the yolk of eggs, iron contained in a nucleo-albumen: that and similar nuclein compounds they believe to be the source of absorbable iron while inorganic salts of iron are only useful in combining with the free  $H_2S$  in the intestines forming  $FeS$ , thus preventing a similar formation with the nuclein iron.

I would advance the hypothesis that inorganic salts resist chemie decomposition and are absorbed or pass into the blood current only in so far as they combine with the Nucleinic Acid, (which we have seen was so universally present in the vital and haematogenic organs), and that they become converted into nucleids by natural action, or, to state it in other words: inorganic salts of iron and other metals must undergo chemie reformation into nucleids of the metals before the organism can make use of them as nutrients or reconstructives.

This hypothesis would explain the physiologic action of the nucleids under consideration.

Physiologic researches on lower animals and clinic experiments have demonstrated that these new synthetic salts have great therapeutic possibilities.

Salkowski<sup>40</sup>, working with nucleinic acid iron has shown that it causes marked increase of the iron in the organs, especially the liver, of rabbits (300 per cent. in ten days), to which it had been administered internally. In the tests the rabbits were given, in addition to their regular food, 2.5

grams of nucleinie acid iron, for ten day periods. In the following table the iron contents of the liver is calculated in M. G. per K. G. of animal weight.

Iron Admd.	No. of Test. Animals	Iron in Liver
None .....	3	3.04
Albuminate of Iron...	2	4.52
Albuminate of Iron...	2	4.12
Nucleinie Acid Iron..	4	9.05

After an experience with Nargol in the treatment of over two hundred and forty cases of the various phases of conjunctivitis (of gonorrhoeal and other pyogenic types), of vernal catarrh, corneal ulcer, etc., *Schwarz*<sup>41</sup>, using solutions ranging from 5 to 30 per cent. concludes that Nargol is practically non-irritating, has considerable astringing power, penetrates deeply, is more stable and more satisfactory than other silver compounds. He also observed that all of the solutions caused blanching of the conjunctiva.

Hartridge<sup>42</sup>, has used 10 per cent. solutions of Nargol in cases of acute contagious ophthalmia and suppurative conditions of the lachrymal sac and finds that they cause no pain, are pleasant to use, and are efficacious, cutting short the attack, etc.

Wippem<sup>43</sup>, reports three obstinate cases of empyema of the maxillary antrum which he was able to cure with  $\frac{1}{4}$  of 1 per cent. solutions of Nargol, after persistent and futile use of other methods of treatment.

Martin<sup>44</sup>, places Nargol first in his estimation of the Silver Salts for use as a remedy in Gonorrhea. He finds that the treatment of acute and chronic inflammations of the genito-urinary mucous membrane, and in acute and chronic cystitis, by injection and instillations of Nargol is followed by the most happy results.

Lydston<sup>45</sup>, thinks that "Nargol, the new compound of Silver and Nucleinie Acid merits a trial."

In view of the demonstrated value of silver salts in the treatment of Gonorrhea it seems as though the silver nucleid would be particularly valuable in this disease and clinical experiments are being conducted to ascertain this point.

While the old fashioned blue stone still has a prominent place among remedies for

the treatment of granular ophthalmia, etc., the nucleid of Copper (Cuprol) seems to be fast displacing it.

*Snell*<sup>46</sup>, reports having used Cuprol in several cases of trachoma, using the dry powder and 5 per cent. solutions alternately with very encouraging results.

He finds that the powder is so impalpable that it does not immediately irritate and that the discomfort is very slight as compared with the application of blue stone.

Von Sicherer<sup>47</sup>, after using Cuprol for ten months finds it especially remarkable because of the absence of pain and irritation following its application. He has used it in many cases of acute and chronic catarrh of the conjunctiva and in obstinate cases applied the dry powder, the pain attending this procedure is slight, and a local anaesthetic is never necessary.

*Butler*<sup>48</sup>, points out that copper is a very valuable alterative nervine, although neglected by modern physicians.

Hare<sup>49</sup>, states that strong claims for copper have been brought forward as a valuable remedy in Anaemia, as a stimulant to the tissues, and as for local use in pharyngitis, etc.

It is rational to believe that Cuprol would be used with satisfaction in such cases as Butler and Hare describe.

Ayres<sup>50</sup>, has used the mercury nucleide (Mercuriol) in the treatment of Syphilis, very extensively: he reports a series of one hundred and eighty cases so treated, of which he presents a tabulation of ninety-five cases, in which he states that sixty-seven cases had no other medication than mercuriol. In fifteen out of the remaining twenty-eight the addition of iodide of potassium was found to be sufficient to control the disease, while in six others the addition of an iron tonic sufficed for this purpose.

Ayres concludes that Mercuriol is the most satisfactory form for the administration of mercury in the treatment of syphilis.

Guiteras<sup>51</sup>, concludes after treating one hundred and fifty cases of specific urethritis with Mercuriol solutions, beginning with  $\frac{1}{4}$  of 1 per cent. and increasing to 5 per cent. that it is a very efficient and safe remedy to use in this way. He lays special stress

on the fact that of this series only two developed complications: one a Gonorrheal Rheumatism and the other an epididymitis, an extremely low per centage.

Smith<sup>52</sup>, has used Mercurool in solution in cases of gonorrheal ophthalmia, chronic conjunctivitis, blepharitis, phlyctenula, ulcers of the cornea, acute and chronic suppurative otitis media, before and after cataract operations, and reports very gratifying results. He also uses Mercury Nucleid in ointments in preference to the yellow oxide.

Frale<sup>53</sup>, reporting on the use of Mercurool in the treatment of Gonorrhea, shows that relief of the symptoms was promptly and that the average duration of the treatment was twenty-six days.

Burtenshaw<sup>54</sup>, in reporting a case of exudative pericarditis, in the course of which a severe cystitis arose, speaks very favorably of irrigations of Mercurool, which almost immediately relieved the patient after other remedies had failed and when, within four days, completely cured the cystitis.

Darche<sup>55</sup>, is enthusiastic over a combination of Mercurool, boric acid, and Chloretone, which he has used in ointment, suppository and bougie in the treatment of ulcers of leg, ulcers of rectum, ulcerated hemorrhoids, pruritus vulvae, and acute gonorrhea.

Lake<sup>56</sup>, has used Mercurool extensively in the treatment of acute and chronic suppurative otitis media, in operations, (ossicleectomy and opening the frontal sinus), irrigating maxillary antrum, etc., such treatment being followed by satisfactory results.

Scherck<sup>57</sup>, finds that Mercurool possesses strong germicidal properties, penetrating the tissues more deeply and with less irritation than other remedies in genito-urinary diseases.

Martin<sup>58</sup>, believes Mercurool to be the most satisfactory Gonococcide we have.

Stone<sup>59</sup>, used twenty grains of Mercurool to the ounce of vaseline as an ointment in dressing ulcers of the leg preparatory to skin grafting in seven cases. In from five to ten days the ulcers were healthy and ready for grafting and in every case the grafts took so that at the end of two weeks the patients were discharged.

#### DEDUCTIONS.

a. These new salts of Nucleinic acid are rational reconstructives: they are true tonics: They increase physiologic resistance: they increase the functional activity of secretory organs.

b. They are powerful germicides while not harmful but beneficial to the tissues.

c. If our present knowledge of nucleins and leucocytosis is correct, then the nucleid is the proper form for administration of metals.

d. We do not positively know the rationale of their action but we have nothing which holds out such prospects for successful medication.

e. These new synthetic salts are valuable additions to the pharmacopeia.

#### Citations.

1. Vaughn: Annual Address—Transactions Illinois State Medical Society—1894.
2. Aulde: New York Medical Journal—Sept. 29, 1894.
3. Vaughn: Journal of the American Medical Association—June 2, 1894.
4. Foster: Text Book of Physiology, London, 1895, part 1, page 40.
5. Halliburton: Journal of Physiology—Cambridge & London, 1892. Vol. XIII, p. 806.
6. Schafer: Text Book of Physiology, Vol. I, p. 83.
7. Forrest: Journal of Physiology—Cambridge & London, Vol. XVII, p. 174.
8. Hoppe-Seyler: Med. Chemic. Untersuch., Berlin, 1866, Heft 3.
9. Plosz: Archiv. f. des. ges. Physiolog., Bonn, Bd. VII, S. 371.
10. Botazzi: Ann. di Chim. e di Farm. 1895, Vol. XXI.
11. Halliburton: Journal of Physiology. Cambridge & London, 1892. Col. XIII, p. 806.
12. Halliburton: Journal of Physiology. Cambridge & London.
13. Kossel: Zeitschr. f. Physiol. Chem., Strassburg 1896. Bd. XXII, S. 172 & 188.
14. Hedin: Zeitschr. f. Physiol. Chem. S. 191.
15. Miescher: Archiv. f. exp. Pathol. u. Pharm., Leipzig 1896, Bd. XXXVII, S. 100.
16. Baumstark: Zeitschr. f. Physiol. Chem. Strassburg Bd. IX, S. 145.
17. Schindler: Zeitschr. f. Physiol. Chem. Strassburg 1892, Bd. XIII, S. 438.
18. Schafer: Journal of Physiology—Cambridge & London, 1893. Vol. XV, p. 100.
19. Gourlay: Journal of Physiology—Cambridge & London, 1894. Vol. XVI, p. 20.
20. Foster: Text Book of Physiology—London 1895. Pt. 11, p. 798.
21. Vaughn & McClintock: Medical News—December 23, 1893.
22. Vaughn: Journal American Medical Association, June 2, 1894, p. 825.



23. Metschnikoff: Modern Medicine—April, 1895.
24. Schafer: Text Book of Physiology, Vol. I, p. 83.
25. Vaughn, etc.: Medical News, May 20, 1893.
26. Schwickerath: Monograph—New Series of Therap. Agents, Mercuriol, etc., Detroit, 1901.
27. Kossel: Zeitschr. f. Physiol. Chem. Strassburg, 1896. Bd. XXII S. 172 & 188.
28. Schafer: Text Book Physiology. Vol. I.
29. Hoppe-Seyler: Handbuch d. Physiol.—Pathol. Chem. Anal. (5 Auf.) 1883, S. 303.
30. Schwickerath: Monograph on Nucleides—Detroit, 1901.
31. Schwickerath: Monograph on Nucleides—Detroit, 1901.
32. Bunge: Physiological and Pathological Chemistry, 1890.
33. Schafer: Text Book of Physiology, Vol. I, p. 879, 880 & 885.
34. Aporti: Bristol Medico-Chirurgical Journal, 1901, December.
35. Schafer: Text Book of Physiology, 1898, Vol. I, p. 431.
36. Rohmann: Archiv. f. d. ges. Physiolog. Bonn 1887, Bd. XLI, S. 411.
37. Bunge: Physiol. and Patholog. Chemistry, 1890.
38. Bunge: Zeitschrift f. Physiologischen Chemie. 1884, Bd. 9, p. 49.
39. Schmiedeberg: Zeitschrift f. Physiologischen Chemie. 1895, Bd. 20, p. 398.
40. Salkowski: Central. Blatt fur d. Med. Wissenschaften, 1900, No. 51.
41. Schwarz: Medicine—March, 1902, p. 211.
42. Hartridge: British Medical Journal—Nov. 2, 1901.
43. Wipperm: Medical News—Nov. 9, 1901.
44. Martin: Therapeutic Gazette—Jan. 5, 1900.
45. Lydston: Surgical Dis. of Genito-Urinary Tract.
46. Snell: Lancet, Sheffield, Sept. 14, 1901.
47. VonSicherer: Die Ophthalmologische Klinik—Stuttgart, No. 23, Dec. 5, 1901.
48. Butler: Journal American Medical Association—Vol. XXXVIII, p. 157.
49. Hare: Therapeutics—p. 179.
50. Ayres: Lancet—London—Oct. 19, 1901.
51. Guiteras: Lancet—London—Sept. 22, 1900.
52. Smith: Physicians & Surgeon—April, 1899.
53. Fraley: Therapeutic Gazette—Nov. 15, 1899.
54. Burtenshaw: Medical News—Mar. 11, 1899.
55. Darche: Canadian Practitioner—April, 1901.
56. Lake: Lancet—December, 1900.
57. Scherck: Therapeutic Gazette—Vol. XVII.
58. Martin: Cincinnati Lancet-Clinic, July 20, 1901.
59. Stone: Medical Age—April 25, 1901.

## SYSTEM IN MEDICAL PRACTICE.

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This paper is written for the purpose of showing in a brief way how doctors may better conserve their time and energies and is in response to many inquiries I have had regarding the card system as adapted to the needs of the busy practitioner. The duties of life have become so numerous and exacting that the old methods must give way to new and more progressive ones. The doctor whose whole armamentarium consisted of saddle bags and lancet has been forced to adopt modern offices with full modern equipment, as the self made doctor, without college education or medical degree, has been replaced by the M. D. produced by four or five years of graded study in a thoroughly equipped college with from ten to fifteen practical working laboratories.

These changes have produced men who must do more work. They do not necessarily see more patients, but give each one far more attention. This is an age when the details must be cared for, and they are multitudinous.

One practical question with every ambitious and conscientious man, is how can he carefully look after the business side of his profession, that is "keep books" so that accounts will always be posted and statements ready when called for; keep careful records of his cases with signs, symptoms and diagnosis, record operations with their findings and results; read, analyze, classify and assimilate his current medical literature, and have it at hand for ready reference; prepare papers and attend to the various other duties connected with medical societies; give careful attention to correspondence, and keep accessible what one writes, as well as what one receives; and keep invoices and receipts carefully and properly filed. This indicates briefly the topics which will be taken up in this paper. Necessarily their treatment will be short, and for the most part simply suggestive to those who may desire to adopt more modern methods.

Before we enter into the consideration of any details there is one proposition which

must be thoroughly understood. Any system, to be successful, must save time and energy, or what amounts to the same thing, or is better, it must enable us not only to save our time and energies, but must also enable us to increase the quality, as well as the quantity and accuracy of our accomplishments. If it does not do this it cannot be considered successful. This must be the test for what follows.

It goes without saying that such a system pre-supposes the use of cards instead of books. The day of books for such purposes has passed. If you are not fully convinced on this point a few hours investigation of any thoroughly up-to-date public library, and of a few of some business houses using modern methods, will serve to finish your conviction.

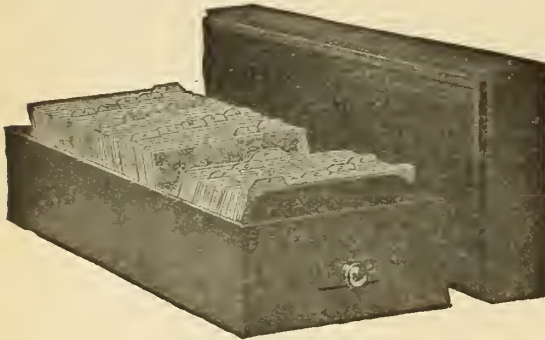


Fig. 1.

Simplest form of tray for cards.

The card system is not altogether new, as slips and cards were used in France in the seventeenth century, and have been more or less in use ever since. They were usually, however, temporary expedients. Their use for permanent records is of very recent origin. The development of the modern card system is American. Much of its development is due to Melvil Dewey and the Library Bureau. For fifteen years this was the only concern which manufactured cards and other accessories to the card system, exclusively. To them through the American Library Association is due the credit of establishing uniform standards of size, which is an exceedingly important matter. While cards were first used in Museums and later in Libraries, they are now used in every business and trade, and each year sees them adapted to new uses.

So much for the Historical. The foundation elements of a card index are, first the card, second the guide, and third the box or drawer in which these are contained. In Fig. 1, you will find these elements illustrated.

The data which you wish to record is on the card, and the guide which stands up above the cards, carries an index letter and is simply an aid in finding a given card quickly. The more guides properly distributed, the more readily are the cards found. These foundation elements are subject to great modification.

The use of cards offers special attractions to the busy physician. It is not my intention to discuss the theory of card using, or to enter into any detailed account of the various forms on the market and the various uses to which they are adaptable. It is my intention simply to relate my own method of using cards and to illustrate the various card forms, indexes, and cabinets, which I have in actual daily use, fully realizing that it is far from perfect. I use card indexes for five principal purposes.

- a. All bookkeeping, including the ledger.
- b. All records of cases.
- c. Topical index to current literature.
- d. Alphabetical index to authors in current medical literature.

- e. For the systematic filing of correspondence, invoices, receipts, catalogues, etc.

Bookkeeping. All my cards for whatever purpose are of a uniform size. The 33L card is the one used. Its actual size is illustrated in the cuts. It will be noticed that the first four lines of all the cards are for bookkeeping purposes, and provide space for the name, and residence of the patient, the date, the character of services rendered, and the amount charged, with an additional line for entering any credit. For convenience this is on all the cards.

The special advantages of cards for bookkeeping is that they are simple, accessible, accurate and expansive. The cards are small enough to fit the average pocketbook, and can always be carried in the pocket. In this way you have your card of original entry always with you. Visits can be recorded at the bedside, with the amount charged and

date. This never requires transferring to any other card or book, which insures accuracy in accounts. A new card is used for each service rendered the patient, or at least for each day.

Record keeping. The time has gone by when the progressive physician can afford to neglect his records. If it is business-like and necessary for Life Insurance Companies, Gas Companies, and other purely business organizations to keep such accurate records of their affairs how much more necessary and desirable is it that the physician should keep an accurate record of the conditions affecting his patients and the treatment applied.

noticed that each one provides space for the record, but that the record and the account are provided for on the same card. In this way, one card with one entry of the patient's name answers both purposes. The smaller card is more desirable for this purpose, because many of our entries will be very brief, and for the few which are long, several cards can be used.

Fig. II illustrates the simplest form of card and provides for a brief memorandum of the complaints of the patient, followed by the treatment or prescription given.

The reverse side of the card can be used if more space is needed. If a written prescription is given the patient, a carbon

<i>Diagnosis</i>			
<i>Complaints -</i>			
<i>Treatment -</i>			

Fig. II.

General card for accounts and record.

Record keeping is no longer subject to argument as to its desirability, or even as to its necessity. It is simply a question of how these records can be most accurately and conveniently kept. Many of the plans which have been devised for record keeping, fail by their own weight. They are too voluminous and cumbersome for the busy physician to use, and he abandons them in desperation. Here again we fall back upon the simplicity and adaptability of the card system.

By referring again to the illustration of the various cards which are used it will be

paper will save the necessity of copying.

For any case which requires more investigation the card illustrated in Fig. III should be used first. This provides for a brief memorandum regarding the personality of the patient, and a record of previous illnesses.

Fig. IV provides for the family history of the patient, and should be used where a more searching inquiry is begun.

For memorandum of physical examination the card shown in Fig. V is used. It is usually necessary, however, in using this card to supplement it by a blank card; for



example, we may find the Glandular system greatly at fault, while there is very little to be recorded regarding the Circulatory, Res-

we use Fig. II for making the detailed entries of the pathological glandular conditions. It would be still better to have a

<i>Diagnosis</i>			
<i>Personal History, Age</i>		<i>Sex</i>	
<i>Birth Conditions</i>		<i>Nationality</i>	
<i>Occupation</i>		<i>Habits</i>	
<i>Circumstances</i>		<i>Temperament</i>	
<i>Previous Illnesses with date, duration &amp; conditions of recovery</i>			

Fig. III.  
Personal history card—short form.

piratory, Digestive, Integumentary, Motor, special form for each system. Specialists  
Urinary, Generative or Nervous systems. In have such forms.  
such case we use card No. V for making In such case we may have from four to

<i>Family History</i>			
<i>Living</i>			
<i>Name</i>	<i>Age</i>	<i>Health</i>	<i>Case of Death</i>
<i>Father</i>			<i>Duration of Illness</i>
<i>Mother</i>			<i>Previous Health</i>
<i>Sons</i>			
<i>Brothers</i>			
<i>Dead</i>			
<i>Living</i>			
<i>Sisters</i>			
<i>Dead</i>			
<i>Have parents grand parents brothers sisters Uncles or Aunts had Consumption or Disruptive Cancer Insanity Epilepsy Gout Rheumatism?</i>			

Fig. IV.  
Family history card.

a brief memorandum as to the condition of each of these systems, while for the Glandular system, which is most at fault, six cards as the result of our primary examination. These will really comprise less space than any book scheme covering the

same amount of ground. Of course each physician can vary the form on the cards to suit himself. Those I am using were

This well illustrates the expansive feature of the card system. You can use either one card or a dozen cards, without in the


Circulatory

Resp.

Digestive

Glandular

Integumentary

Motor

Urinary

Generative

Nervous

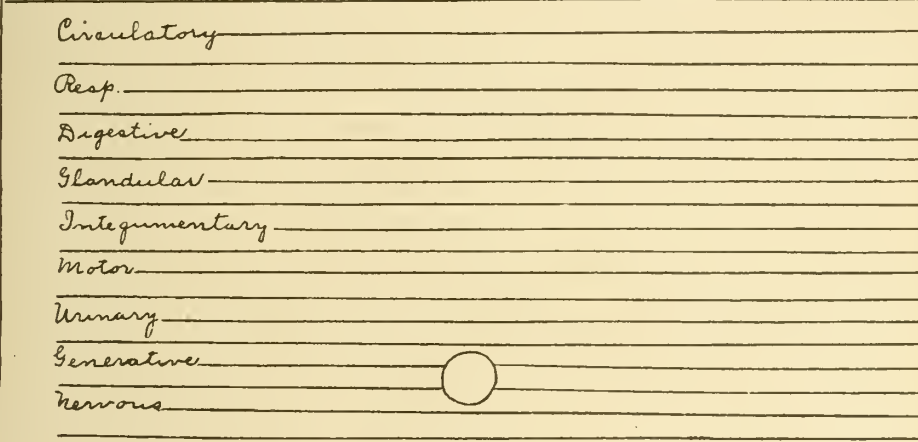


Fig. V.  
Card for memoranda as to each system.

selected from some of our standard works on diagnosis, and have been fairly satisfactory.

least embarrassing its expansiveness. It can be used in a practice of ten patients per day, or fifty patients per day without the least difficulty.

In addition to the data indicated, we

[illegible]

Fig. VI.  
Urinalysis card.

should always have an examination of the urine, which is recorded on the card illustrated in Fig. VI.

Fig. VII is used for all accident and injury cases and contains space for all memoranda necessary in filling out the ordinary

railroad or accident insurance report. On the reverse side of the card the names of witnesses to the accident and other similar data can be placed.

tarium, in responding to an accident case, or any case for that matter, should be proper facilities for making a record of the facts.

I have recently adopted Keen's charts, for

<i>Diagnosis</i>			
<i>Age</i>	<i>Sex</i>	<i>Civ Cond</i>	<i>Nationality</i>
<i>Occupation</i>		<i>Date of Injury</i>	
<i>Previous Illnesses or Injuries with dates, duration &amp; cond of recovery</i>			
<i>Condition of patient</i>			
<i>Cause</i>			
<i>Location</i>			
<i>Character</i>			
<i>Extent</i>			
<i>Services Rendered (over)</i>			

Fig. VII.  
Card for record of injury.

The surgeon should not only hear what the patient and others have to say of the accident, but he should be prepared to make some record of it. A part of his armamen-

which P. Blakiston Sons & Co., have made for me according to my special order, a set of eight rubber stamps. They are made of the proper size to stamp on the cards,

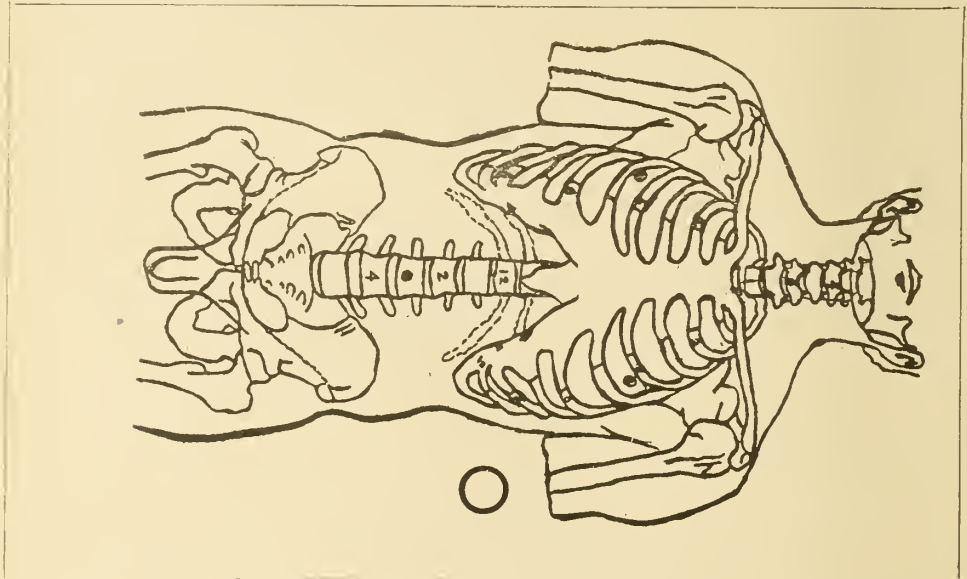


Fig. VIII.  
Anterior portion of body—rubber stamp diagram.



Thus you see that besides the written description, which to be complete must be voluminous, one can quickly indicate on a diagram the nature and extent of an injury.

Fig. VIII shows the front of the body. Each bone is outlined, as is also the form of the body. Any injury occurring to the front portion of the shoulders, neck, ribs,

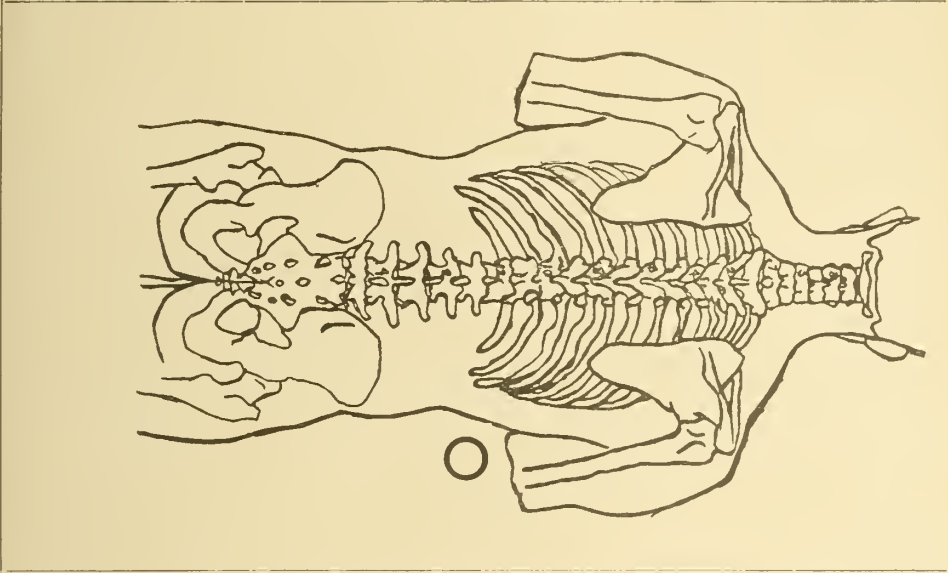


Fig. IX.  
Posterior portion of body—rubber stamp diagram.

Of course the stamps cannot be carried in the pocket, but can be used on the back of the card of original entry after returning to one's office.

abdomen or pelvis can be quickly located.

Fig. IX represents the posterior part of the body, showing the vertebral column, scapula, ribs and pelvis. And it is especially

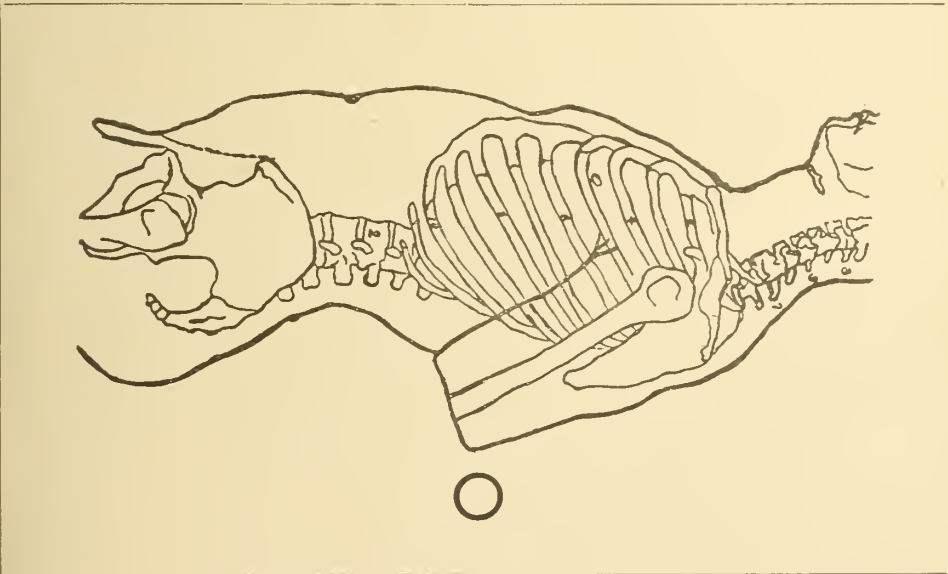


Fig. X.  
Left side of body—rubber stamp diagram.

useful for injuries about the spine or back or posterior portion of the shoulder.

Fig. X shows the right side of the body, and is very useful in showing accurately the

Fig. XII shows the arms, hands and fingers. The anterior and posterior portions of all the bones from the shoulder to the finger tips are shown. These are

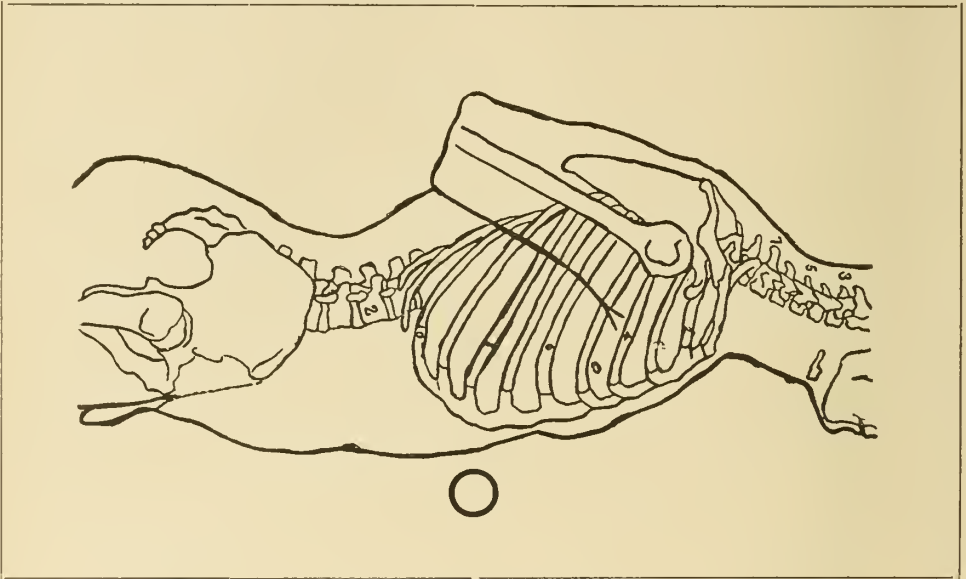


Fig. XI.

Right side of body—rubber stamp diagram.

location of injury, disease or tumors of the side.

Fig. XI shows the left side of the body and is adapted to the same use as Fig. X.

specially useful in fractures and dislocations of the upper extremity, but any injury, operation, paralysis or seat of pain can be accurately recorded.

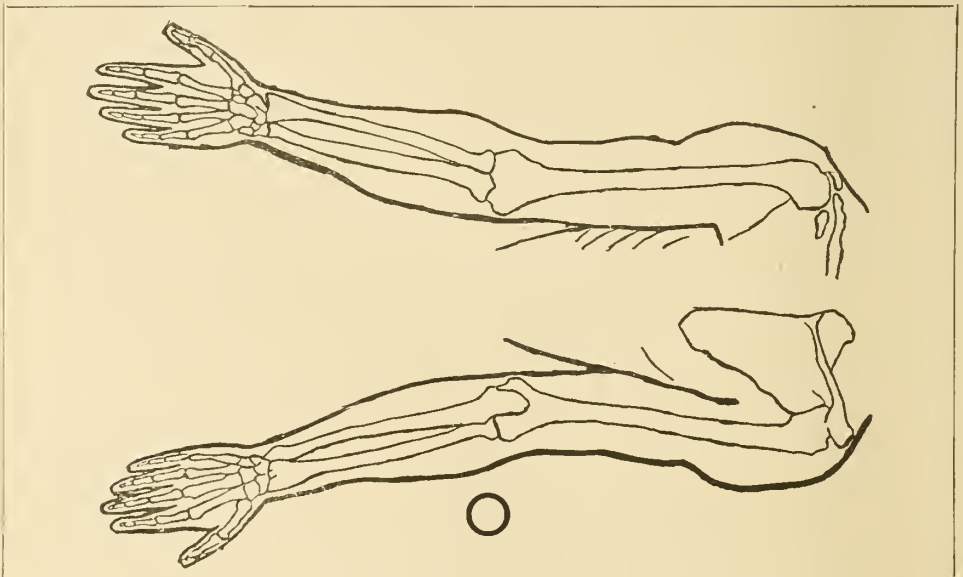


Fig. XII.

Arms and hands—Anterior and Posterior—rubber stamp diagrams.

Fig. XIII shows the lower extremities excepting the feet, and is useful in the same way as Fig. XII.

Fig. XIV shows the neck, face and head,

recording injuries of the feet and ankles.

No description of an injury or seat of pain, or area of paralysis is so accurate as that carefully outlined on a diagram. For

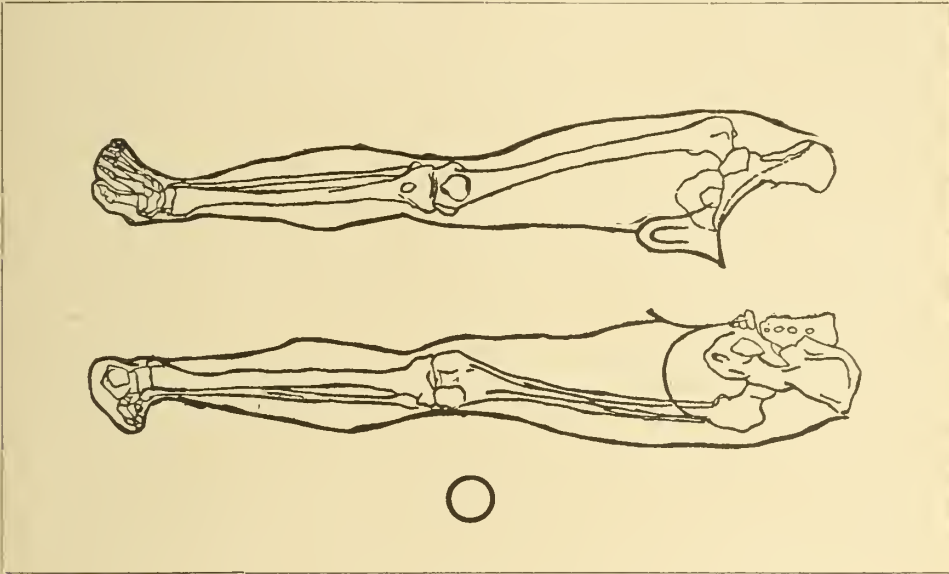


Fig. XIII.

Legs—Anterior and Posterior—rubber stamp diagram.

and is probably the most useful of all.

Fig. XV supplements Fig. VIII in that it gives a larger view of the bones and tissues of the feet. All of these are very useful in

this reason railroad companies require their surgeons to indicate on a diagram the location of the injury.

Fig. XVI shows a form which I require

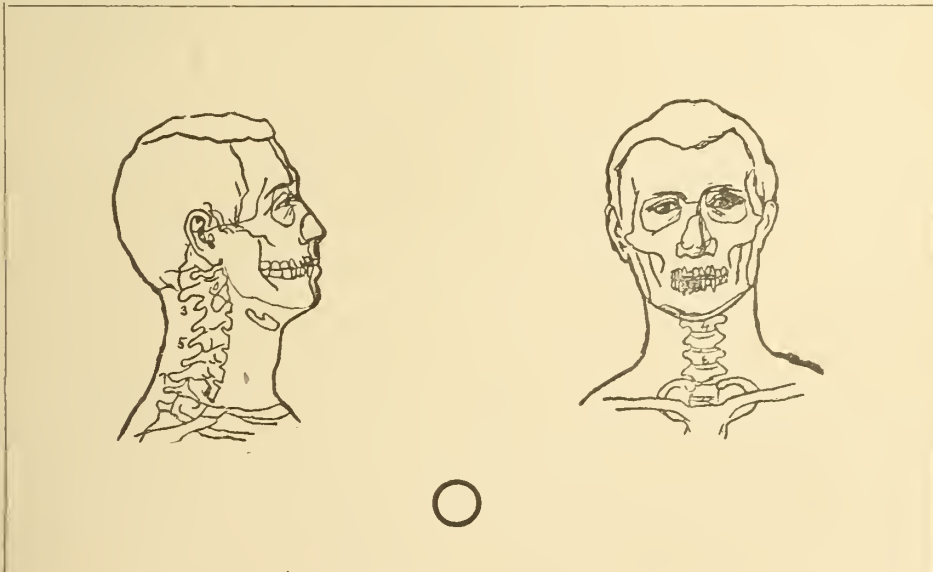


Fig. XIV.

Head, face and neck—Anterior and Lateral—rubber stamp diagrams.



my assistant to fill out for each anaesthetic given.

I always carry several copies of cards Nos. II, III, IV and V in my pocket book, one

If a patient accosts you on the street and pays you money, it is only necessary to take out card No. II, record the patient's name, the date, and the amount paid. On returning

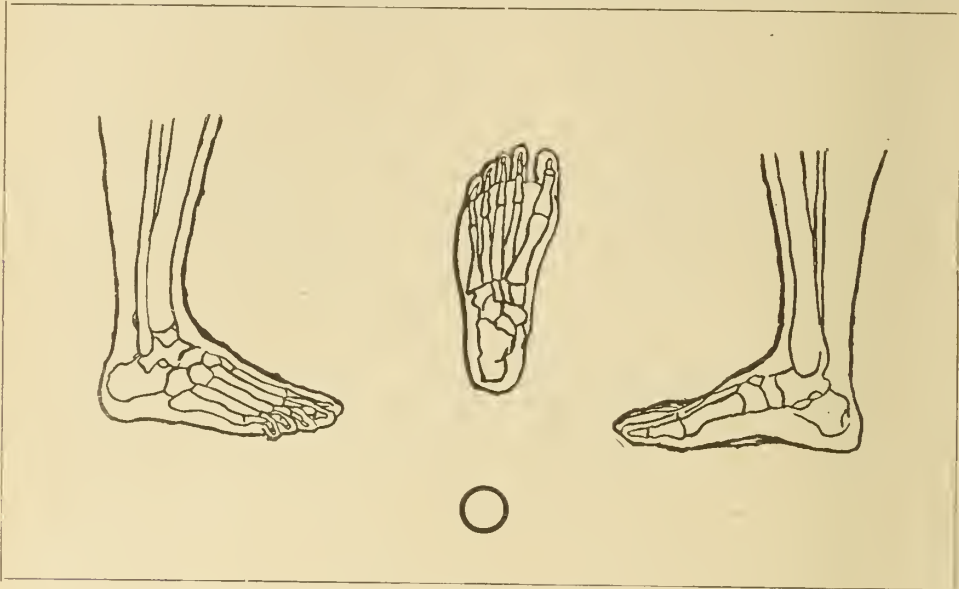


Fig. XV.  
Feet and ankles, both sides and sole—rubber stamp diagrams.

side of which I have had made to carry about 20 cards. In this way one is always provided with the facilities for bookkeeping and record taking, no matter where called.

to the office these cards are simply put in their proper place in the filing cabinet.

To facilitate the balancing of accounts it is necessary to have a ledger card on which

<i>To Anaesthesia for Operation</i>						
<i>Diagnosis</i>						
<i>Age</i>	<i>Sex</i>	<i>Color</i>	<i>State</i>	<i>Height</i>	<i>Weight</i>	
<i>Habits</i>				<i>Complications</i>		
<i>Phys. Condition</i>				<i>Stimulants</i>		
<i>Heart</i>						
<i>Lungs</i>						
<i>Kidneys</i>						
<i>Bowels</i>						
<i>Preparation</i>						
<i>Anaesthetic began</i>				<i>m and ended</i>	<i>m</i>	
<i>Operation began</i>				<i>m and ended</i>	<i>m</i>	
<i>Time to produce narcosis</i>						
<i>Anaesthetic</i>	<i>Time</i>	<i>Dosage</i>	<i>Remarks</i>			
<i>Ether</i>	<i>m</i>	<i>c.c.</i>				
<i>Ethyl Bromid</i>	<i>m</i>	<i>c.c.</i>				
<i>Chloroform</i>	<i>m</i>	<i>c.c.</i>				
<i>Aether</i>	<i>m</i>	<i>c.c.</i>				

Fig. XVI.  
Anaesthetic card.

[illegible]

Fig. XVII.

Photographic reproduction of complete account and record of case. No. I, ledger card. Nos. II and III, account and history No. IV, urinalysis No. VI, memoranda of visits at hospital No. VII visit at home. No. VIII, IX and X, record of payments closing account.

the various amounts are entered in order each day. In Fig. XVII is illustrated a complete account with its records. You will notice the first card is a ledger card, which also acts as the guide card in the cabinet. It will be noticed that a part of this ledger card stands higher than the other

After an account is closed the cards, as matters of bookkeeping, are of no further use excepting to show that the patient has paid his account in full. But as a record of the case they are very instructive and important. Therefore, they are removed from the drawer containing live accounts and

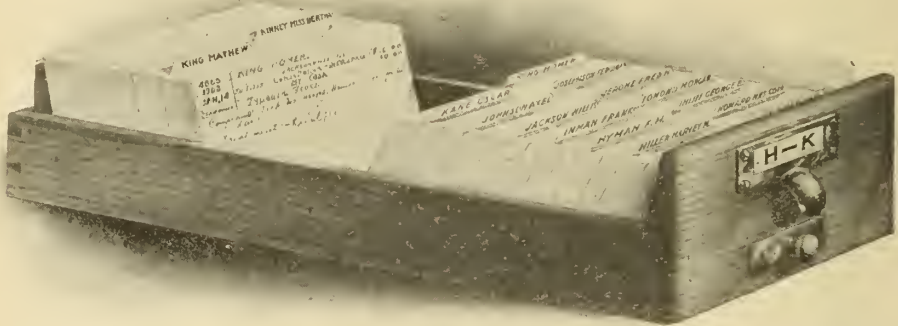


Fig. XVIII.

Open drawer showing arrangement of ledger and day cards.

eards and contains the name of the patient. These are arranged in alphabetical order in the drawer. Alphabetical guides are also used to facilitate finding names.

By examining this illustration (No. XVII) it will be seen that we have made use of cards No. II, No. VI, and No. XIII.

placed in a transfer drawer, which contains records of past cases and incidentally shows the result of the account. In this way our regular ledger drawers never become encumbered with dead accounts. As soon as an account is paid, or otherwise settled, it is removed from the ledger drawer to the



Fig. XIX.

Cabinet used for day cards and ledger.

These cards, including the ledger card, contain all the information necessary about this patient and close the account. Fig. XVIII shows an open drawer with the ledger card containing the name standing up above the ordinary cards. One day card is exposed and well illustrates the appearance of ledger, day and record cards.

drawer containing transferred records. It is just as accessible here and does not encumber our live accounts. There is never a new ledger to be opened. The ledger is always new and live, and all accounts in it are either in the process of making or are supposed to be collectable.

Fig. XIX illustrates the cabinet in which



live accounts are kept. There are newer forms of cabinets for this purpose which are even more desirable, but this has answered my purpose very well. However, it must not be supposed that I began the card system by using this size cabinet. My first card cabinet is illustrated in Fig. XX, and provides for about two thousand cards with a sufficient number of guides. It is undesirable to begin with too large a cabinet. The needs of each one will be somewhat different, and it is far better to grow into the use of the card system than to try to adopt it all at once. When one is fully acquainted with its advantages there is no danger of returning to cumbersome books.

The form on the cards illustrated is printed with the mimeograph. I do this myself, and can change the form from time to time

as seems desirable. They look a little better printed in type.

Before leaving the consideration of case records I wish especially to call your attention to a plan of grouping my case records so that all similar cases come together.



Fig. XX.

Two tray cabinet for 2,000 cards.

The cards illustrated in Fig. XXI are of a blue color. On this the diagnosis is the first item, and in the left hand corner, instead of the consecutive number should appear the classification number. This has accidentally been omitted in the illustration. This number is the Dewey Decimal number which will be considered further on in the paper. By using the Dewey Decimal classi-

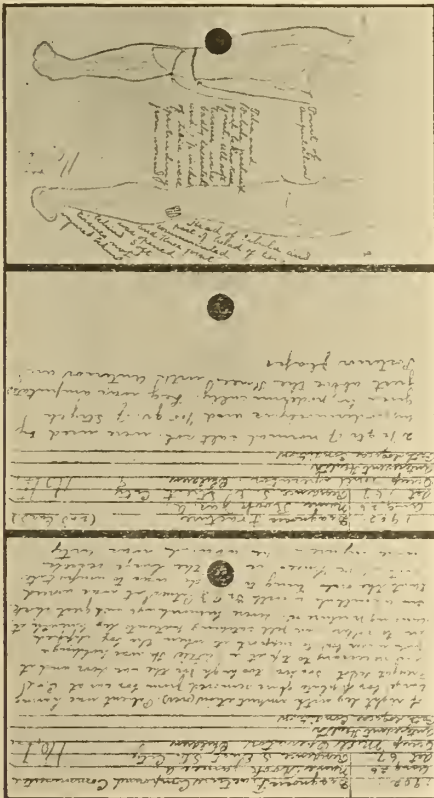


Fig. XXI.

Photographic reproduction of history cards (blue cards) from classified histories of cases—classified by diagnosis and arranged chronologically in each class. (See Fig. XVII.)

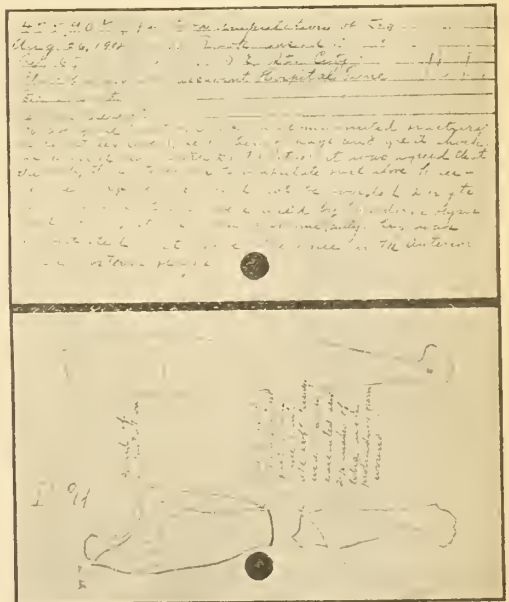


Fig. XXII.

Photographic reproduction of operation card from classified index of operations and arranged chronologically in each class.

fication all similar topics will have the same number and will fall together in the index.

Fig. No. XXII illustrates the operation card. These are salmon colored cards, and the first item is the operation. In this way all similar operations are grouped together. The diagnosis cards and operation cards are simply copies of the original record and are made for convenience. Instead of making out the full card one could simply keep a classified index of the cases. This would, however, necessitate going back to the origi-

it is almost as easy to make two copies as one. The carbon copy can always be retained and filed away with the letters received. The letters for each correspondent are placed in a separate folder.

These folders are numbered and put away in numerical order. For this purpose I use a vertical filing cabinet, which is illustrated in Fig. XXIII, I always put all invoices and receipts in the same folder. All my correspondence with Smith & Jones, dealers in surgical instruments, including letters received, letters written, invoices and receipts will be found in folder No. 508, and if these are properly put away they will appear in consecutive orders as to dates.



Fig. XXIII.

Vertical letter file, showing arrangement of folders.

nal record in order to get the desired data. These cards can be made by the office assistant and will often simply consume time which would otherwise be lost.

The care of correspondence, invoices and receipts is the next item which should be considered in arranging an orderly and systematic office. It goes without saying that all correspondence should be put away by some system accessible for future reference. This should include not only the letters received, but also carbon copies of the letters written. With the use of the typewriter

In order to facilitate the use of the letter file there is a card index to it. This index comprises the upper drawers in the cabinet, illustrated by Fig. XIX. This is a simple alphabetical index with plenty of guide cards which make the index very accessible. There are rarely more than six names between any two guides. To illustrate, if I wished to find the correspondence of the Smith & Jones, I look in the alphabetical index of names, which also serves the purposes of an address book, for the Smith & Jones card, and find that their correspond-

ence number is 508, which is the number of the folder in the vertical file. This system of filing is perfectly expansive, and by the use of transfer boxes old correspondence can be eliminated quickly from the new.

This brings us to a consideration of our Current Medical Literature. Simply to read our medical journals as we may have time, and then throw them aside, is to deprive ourselves of their greatest value. Any one familiar with books and the making of books will tell you that journal literature is fully five years ahead of the books. If this is true, and my experience leads me to believe that it is, no physician desiring to be fully abreast of the times can afford not to have ready access to his journals.

The first question which brings itself to one desiring to make his current medical literature accessible for daily use is, what system or plan of indexing shall be adopted. It is a proposition of easy demonstration that no one should undertake the formation of an index who has not had special training and experience in handling and classifying topics, and who has not access to an enormous number of topics. A good plan of indexing cannot be built on a small scale. I tried several plans without success, and finally decided to adopt a ready made plan. There are a few such plans.

The one which I have adopted is that arranged by Melvil Dewey, formerly secretary of the University of the State of New York and now director of the New York State Library School. This is called "The Decimal Classification and Relative Index Arranging, cataloging and indexing public and private libraries, and for pamphlets, clippings, notes, scrap books, indexes, résumés, etc. This index, which is built upon the decimal plan, divides all knowledge into ten classes, and each of these is again divided into ten divisions as follows:

#### DIVISIONS.

##### 000 General Works.

- 010 Bibliography.
- 020 Library Economy.
- 030 General Cyclopedias.
- 040 General Collections.
- 050 General Periodicals.
- 060 General Societies.
- 070 Newspapers.
- 080 Special Libraries. Polygraphy.
- 090 Book Rarities.

##### 100 Philosophy.

- 110 Metaphysics.
- 120 Special Metaphysical Topics.
- 130 Mind and Body.
- 140 Philosophical Systems.
- 150 Mental Faculties. Psychology.
- 160 Logic.
- 170 Ethics.
- 180 Ancient Philosophers.
- 190 Modern Philosophers.

##### 200 Religion.

- 210 Natural Theology.
- 220 Bible.
- 230 Doctrinal Theol. Dogmatics.
- 240 Devotional and Practical.
- 250 Homiletic. Pastoral. Parochial.
- 260 Church. Institutions. Work.
- 270 Religious History.
- 280 Christian Churches and Sects.
- 290 Non-Christian Religions.

##### 300 Sociology.

- 310 Statistics.
- 320 Political Science.
- 330 Political Economy.
- 340 Law.
- 350 Administration.
- 360 Associations and Institutions.
- 370 Education.
- 380 Commerce and Communication.
- 390 Customs. Costumes. Folk-Lore.

##### 400 Philology.

- 410 Comparative.
- 420 English.
- 430 German.
- 440 French.
- 450 Italian.
- 460 Spanish.
- 470 Latin.
- 480 Greek.
- 490 Minor Languages.

##### 500 Natural Science.

- 510 Mathematics.
- 520 Astronomy.
- 530 Physics.
- 540 Chemistry.
- 550 Geology.
- 560 Paleontology.
- 570 Biology.
- 580 Botany.
- 590 Zoology.

##### 600 Useful Arts.

- 610 Medicine.
- 620 Engineering.
- 630 Agriculture.
- 640 Domestic Economy.
- 650 Communication and Commerce.
- 660 Chemical Technology.
- 670 Manufactures.
- 680 Mechanic Trades.
- 690 Building.

##### 700 Fine Arts.

- 710 Landscape Gardening.
- 720 Architecture.
- 730 Sculpture.
- 740 Drawing. Design. Decoration.
- 750 Painting.
- 760 Engraving.
- 770 Photography.
- 780 Music.
- 790 Amusements.



**800 Literature.**

- 810 American.
- 820 English.
- 830 German.
- 840 French.
- 850 Italian.
- 860 Spanish.
- 870 Latin.
- 880 Greek.
- 890 Minor Languages.

**900 History.**

- 910 Geography and Description.
- 920 Biography.
- 930 Ancient History.
- 940     { Europe.
- 950     { Asia.
- 960     { Africa.
- 970     { North America.
- 980     { South America.
- 990     { Oceanica and Polar Regions.

No. 600, Useful Arts, is the class, and 610, Medicine, is a division which has special interest for the physician. The following gives the principal sub-Divisions under 610:

**610 Medicine.**

- .1, Philosophy, Theories; .2, Compendis; .3, Dictionaries, Cyclopedias; .4, Essays, Addresses; .5, Periodicals; .6, Societies; .7, Study and teaching; .71, Medical schools; .72, Medical education of women; .73, Training schools for nurses; .76, Nat. History of man; .77, Medical museums; .8, Collections; .9, History of Medicine.

**611 Anatomy. Histology.**

- .1 Circulatory System.
- .2 Respiratory System.
- .3 Digestive System.
- .4 Glandular and Lymphatic System.
- .6 Genito-Urinary System. Breasts.
- .7 Motor and Integumentary System.
- .8 Nervous System. Sensory Apparatus.
- .9 Regional Anatomy.

**612 Physiology.**

- .1 Blood and Circulation.
- .2 Respiration.
- .3 Digestion. Absorption. Nutrition.
- .4 Secretion. Excretion.
- .5 Animal Heat.
- .6 Reproduction. Development.
- .7 Function of Motor and Vocal Apparatus and Skin.
- .8 Nervous Functions.

**613 Personal Hygiene.**

- .1 Air and Light.
- .2 Food. Dietetics.
- .3 Beverages.
- .4 Cleanliness of Body. Clothing.
- .5 Human Habitation and Resort.
- .6 Hygiene of Employment.
- .7 Hygiene of Recreation and Sleep.
- .8 Hygiene of Nervous System.
- .9 Hygiene of Offspring. Heredity.

**614 Public Health.**

- .1 Registration and Vital Statistics.

- .2 State Control of Medicine.
- .3 Adulterations. Inspection of Articles Liable to affect Public Health.
- .4 Contagious and Infectious Diseases. General.
- .5 Contagious and Infectious Diseases. Special.
- .6 Disposal of the Dead.
- .7 Hygiene of the Air and Ground. Nuisances.
- .8 Protection of Human Life from Accidents, Casualties.
- .9 Hygiene of Animals. Veterinary Sanitation.

**615 Materia Medica and Therapeutics.**

- .1 Materia Medica. Drugs.
- .2 Inorganic Drugs.
- .3 Organic Drugs.
- .4 Practical Pharmacy.
- .5 Therapeutics. Action of Medicines in General.
- .6 Administration of Medicines.
- .7 Medicines grouped by Effects.
- .8 Other Remedies.
- .9 Toxicology. Poisons.

**616 Pathology Diseases. Treatment.**

- .1 Diseases of Circulatory System.
- .2 Diseases of Respiratory System.
- .3 Diseases of the Digestive System.
- .4 Diseases of the Lymphatic System.
- .5 Dermatology. Skin Diseases.
- .6 Diseases of Genito-Urinary System.
- .7 Diseases of the Organs of Locomotion.
- .8 Diseases of Nervous System.
- .9 General Diseases.

**617 Surgery.**

- .1 Injuries.
- .2 Results of Injuries.
- .3 Orthopedic Surgery. Deformities.
- .4 Surgical Operations.
- .5 Regional Surgery.
- .6 Dentistry. Diseases of Teeth.
- .7 Ophthalmic Surgery. Diseases of Eye.
- .8 Diseases of the Ear.
- .9 Operative Surgery.

**618 Diseases of Women and Children. Obstetrics.**

- .1 Gynaecology. Diseases of Women.
- .2 Obstetrics.
- .21 Pregnancy. Physiology.
- .3 Pathology of Pregnancy.
- .4 Parturition. Labor. Physiology.
- .5 Pathology of Labor.
- .6 Puerperal State. Physiology.
- .7 Pathology of Puerperal State. Puerperal Diseases.
- .8 Obstetric Operations.
- .9 Paediatrics. Diseases of Children.

While there are many things about this classification made by Mr. Dewey, which are very crude in the light of advanced medical science and which require revision, it is far better than anything a busy practitioner could build for himself. This is not the only classification in use by librarians. That of Cutter has some advantages to physicians,

although it has some defects. Dr. Wire, formerly in charge of the Medical Department of the Newberry Library and who is a physician as well as a librarian, has made some changes in the Cutter system. All three are badly in need of revision. This is a subject which should be taken up by the American Medical Association. A committee should be appointed to thoroughly study all existing medical classifications, and formulate a classification which is at once simple, systematic, comprehensive and scientific. Modern medicine is much in need of scientific classification, as can be demonstrated by the crude tables of contents and indexes which accompany our best books.

It is to be hoped that the Association will find some practical physician with knowledge of the requirements of a classification from the standpoint of the modern librarian, who will take the matter in hand and give the profession a modern, up-to-date and scientific classification, which can be used as a means of ready reference for our current medical literature. However, this classification answers very well for every day use.

I have two cards made for each original article, which appears in the Medical Journals which I take. On the first card the subject is first, the author second, and the Journal with its volume and date third. On the other card the author's name appears first, the subject second, and the name of the Journal with the volume and date third. The writing of these cards is simply a clerical matter, and anyone who can copy can do that work.

These cards are filed away in cabinet No. XXIV in the order of their numbers, each card having a number corresponding with the classification number given by Dewey. This brings all similar topics together and makes them readily accessible. For example, all articles on the subject of Appendicitis are in one group. I can refer to all the articles on a given subject in the current journals which I have taken during the past ten years just as readily as I can find that subject in a single book. In fact, by this plan my journal literature is just as accessible as my books, and is even far more helpful. This

is especially true to one who prepares papers for medical societies, or is for other reasons interested in looking up the whole literature of a given subject.

It has been truly said that "To learn to classify is in itself an education." For this reason there is no more valuable work

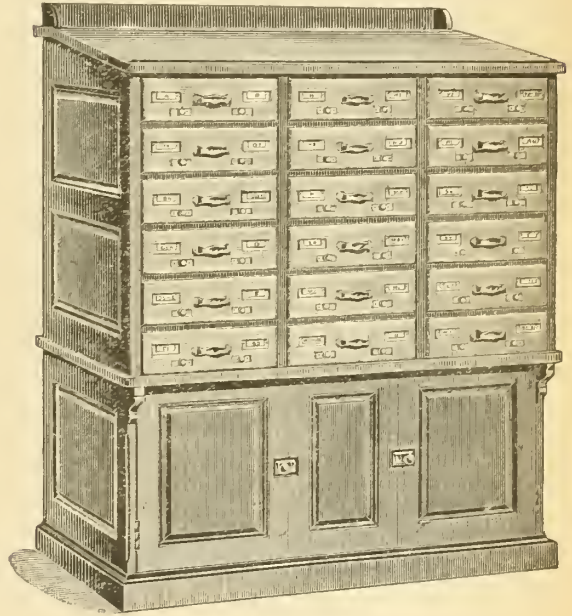


Fig. XXIV.

Cabinet used for index of authors, classified index of current medical literature, classified histories of cases and operations.

than to classify these subjects. Adopting the Dewey classification gives a plan ready made, and it is only necessary to adapt your topics to this plan. By so doing all similar topics fall together. If one is too busy to do this part of the work himself, it does not take long for an assistant to learn to do it. In fact I have had several assistants who could classify quite as well, if not better, than myself. The assistant who will carefully classify your current literature for a few months, or years, will soon be found to be an unusually well posted man in current medical literature. Although it is still better if one can do this work for himself.

In conclusion I wish to acknowledge my obligation to the Medical Fortnightly of St. Louis, The Library Bureau of Chicago, and the Illinois Medical Journal, for the cuts used in illustrating this paper.

## SURGERY OF THE PROSTATE.\*

BY JOHN B. MURPHY, A. M., M. D., CHICAGO.  
 Professor of Surgery, Northwestern University, Chicago  
 Post-Graduate School, etc.,  
 Cases from May 18, 1901, to April 10, 1903.

The surgery of the prostate is rapidly approaching that of the appendix and gall bladder, in its significance to the surgeon and patient. Until very recently, it was not treated in the masterful and efficient manner in which other organs, as the uterus, tubes and stomach, were handled, surgically.

In presenting this subject to you today, I trust I will be permitted to emphasize the importance of the anatomical relations and physiological functions of the prostate mentioned in my recent article on the subject. I will, however, go more into the details of the clinical aspects of the cases.

The etiological factors, the symptomatology, the pathologic conditions of the bladder and kidneys at the time of operation, the technic of the operation and the immediate and remote results will, also, be treated somewhat in detail.

Experience has produced a number of changes in the technic, and as time advances, we are able to procure more speedy and complete recoveries than in our earlier cases. It is to me very gratifying to be able to report 31 consecutive cases of perineal prostatectomy without a single death due to the operation. The ultimate results have been more than I could have expected, and gratifying, as will be shown by a perusal of the individual histories with the later reports of the patients.

Since I called attention to the enlargement of the lumen of the prostatic urethra that sometimes occurs with prostatic hypertrophy, and advised the removal of a portion of its floor, with suture of the lateral walls in the median line to form a new floor, the recoveries have been more rapid and there has been no case in which extra-vesical accumulation of urine during micturation, with dribbling, has occurred. This extra-vesical pouch, or dilated prostatic urethra, can be readily recognized by the surgeon who

carefully examines the prostatic urethra at the completion of his operation. It can, also, be demonstrated on the cadaver when prostatic hypertrophy is present. If this pouch is not recognized by the operator and properly treated, the operation of perineal prostatectomy will fail to produce that primary and complete relief which we desire to secure for the patient.



Fig. 1.

Shows the relation of the prostate to the deep perineal fascia, the rectum, the bladder, the seminal vesicles and ureters. Photographed from dissection by Prof. W. T. Eckley.

It appears to me that supra-pubic prostatectomy will in the future be reserved for the exceptional cases of enormous hypertrophy of the prostate, or cases of pedunculated middle lobe with stone; that the Bottini operation will entirely disappear as a method of treatment for enlarged prostate, seems to me certain, for it is unscientific, inaccurate and hazardous in its technic and unreliable as to its permanent results.

I wish to express my appreciation of the

\*Read at the 52d Annual Meeting, Quincy, May 21, 1902.



many interesting, instructive and unique pathological and clinical conditions of the prostate reported by G. Frank Lydston, from his rich material during the past fifteen years; also, for many valuable suggestions concerning the technic of his various operative procedures, the details of which he may mention, as he is to open the discussion on this subject.

#### ANATOMY.

The Prostate is a glandular and muscular body situated in front of the bladder, entirely behind the triangular ligament or deep perineal fasciae (see Fig. I) immediately anterior to and in close contact with the rectum, and completely surrounds the prostatic urethra. It is tunneled by the prostatic urethra, the urethra occupying the second anterior fifth of the space, from before backward.

Five-sixths of the bulk of the normal prostate is behind the posterior level of the urethra (see Fig. II). Its greatest fixation is by its attachment to the posterior layer of the triangular ligament. When the ligament is divided, therefore, and the prostate freed from it, it permits of considerable latitude of motion. On the anterior surface it is rather loosely attached to the urethra; on the posterior surface it is firmly fixed to the urethra.

The mucous linings of its glands and of the ejaculatory ducts and prostatic sinuses are continuations of the mucosa of the urethra (see Fig. IV) so that it is not possible to remove the entire prostate without removing the prostatic portion of the urethra at the verumontanum (see Fig. II). It is possible to remove the lateral and posterior lobes of a hypertrophied prostate, allowing its isthmus to remain, and retain the anterior portion of the urethra and three-fourths of its circumference (see Fig. V, from Toldt). The anterior urethra is crescent shaped, its convexity forward; the posterior surface of the urethra vaults forward into this crescent, the elevation being made up of the caliculus, utriculus, ductus ejaculatorii and the connective tissue surrounding them, (see Fig. V) and the middle lobe, so-called, behind as shown in Fig. VI.

The middle lobe, in the normal anatomical condition, is a small, bullet-shaped, tongue-like projection from the base of the prostate, posterior to the urethra. It is not a lobe, when compared with the lateral lobes; it is merely a projection in the direction of the bladder from the posterior commissure, between the lateral lobes; and when the lateral lobes and posterior commissure are removed, it is practically detached except from the mucosa, as shown in case 7.



Fig. II.

Shows relation of prostate to perineal fascia, bladder and seminal vesicles. Lateral vein. Photographed from dissection by Prof. W. T. Eckley.

The gland is surrounded by a distinct capsule (Fig. V) which is smooth over the lateral lobes, but is depressed into the gland and divided into layers around the vessels in the median line. This vascular area runs parallel with the urethra and directly in the center line. Capsular divisions, therefore, in the removal of the gland, should be made over the lateral lobes and parallel with the line of the urethra, that this vascular area may not be invaded until the lateral lobes are decapsulated and prepared for extirpation, and hemorrhage thus avoided. The seminal vesicles recede from the prostate (see Figs. III and IV) along the posterior

wall of the bladder and are closely attached to it.

The vesico-rectal peritoneum is a long distance from the base of the prostate, and in subcapsular enucleation its integrity is not in danger of being disturbed.

The arterial supply of the prostate is from the inferior vesical and middle hemorrhoidal arteries. These are subdivided at the inner margin of the capsule into small arterioles, and when the true capsule is peeled off they give rise to little hemorrhage. The veins which form a plexus in the capsule, empty into the vesico-prostatic plexus.

The lymphatic supply is meager; the vessels accompany the venous plexus, and finally end in the internal iliac nodes. The nerves of the prostate are branches of the hypogastric plexus.

In its minute structure, the organ is made up of a stroma of connective tissue, smooth muscular fibers and glandular tissue (see Fig. V). The muscle fibers constitute about one-half of the entire mass of the gland (see Fig. V) and are continuous with the muscle fibers of the bladder wall above; below they are mixed with a small amount of voluntary muscular tissue, derived from the transverse perineal muscles (F. H. Gerish).

The glands are of the branched or tubular variety. They secrete a milky fluid, which at the moment of ejaculation is added to the seminal fluid, and appears to play an important part in the motility of the spermatazoa, as without the addition of this fluid, in some of the lower animals, fecundity cannot take place.

While in its normal anatomical position the prostate stands in front of the bladder and surrounds the urethra (see Fig. II) in its hypertrophied condition it has an entirely different relation to the bladder.

It normally extends backward onto the bladder only to the sphincter vesicae internus (see Fig. VII) which shows the bladder wall with prostate removed. In its pathological or hypertrophied condition, it incapsulates the neck of the bladder in a cuff-like manner, extending many inches upward on its wall, and often protrudes into the vesical cavity, carrying on its surface the muscularis

and mucosa vesicae; occasionally a pedunculated lobe may be extruded through the muscularis and only retain the mucous covering; this, however, rarely occurs except from the posterior lobe. In the normal anatomical condition, the muscular fibers of the prostate are continuous with the muscular fibers of the apex of the bladder wall, but as the prostate enlarges it extends cone-shaped and upward on and around the neck of the bladder, and its muscle fibers in the upper part appear to be distinctly separated from the muscle fibers of the bladder. This anatomical relation gives distinct assistance and guid-

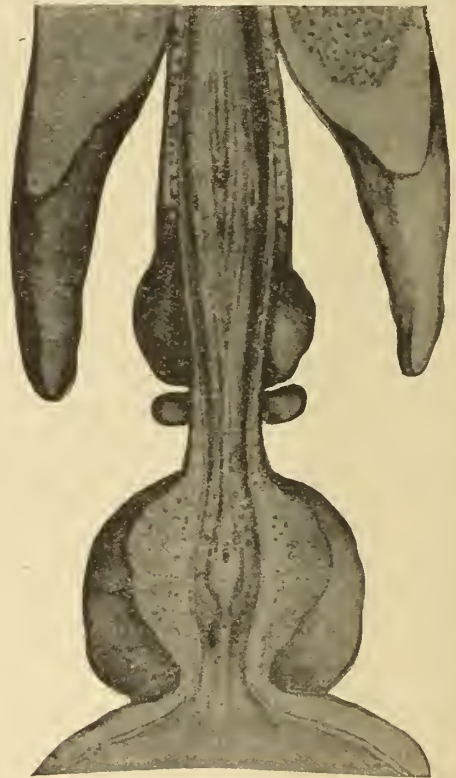


Fig. III.

Shows the relation of the prostate to the prostatic and membranous urethra, as well as the relations to the bladder wall and the seminal vesicles.

ance as to the best method of removal or separation of the prostate from the bladder wall, i. e., at the extreme apex of the bladder it would be difficult to distinguish between the prostatic and bladder muscular fibers, while, if the base of the prostate be exposed, the prostate can be shelled from

the bladder wall, from above downward, with ease and with comparative safety to the integrity of the bladder wall, i. e., if we look upon the prostate as a cuff, closely attached at its apex to the bladder wall, and loosely attached at its base, we can see how its lateral lobes can be scrolled or rolled forward with ease, with the assistance of hook retractors, until it reaches the apex attachment, then it may be divided with the scissors.

the internal sphincter, suffice. This function of the circular layer of fibers, which composes the internal sphincter, is disputed by some observers. That this sphincter controls, absolutely the flow of urine, I have demonstrated conclusively on many of my cases after the prostate was removed, and the posterior prostatic urethra entirely removed with it. It was necessary in these cases to introduce a forceps or a catheter to allow the urine to escape from the bladder



Fig. IV.

Shows the relation of the urethral mucosa to the ejaculatory ducts and prostatic sinuses, and the relation of the prostatic substance to the prostatic urethra.

#### PHYSIOLOGY.

"At the cervix of the bladder the circular layer of muscular fibers is strengthened, and has been supposed to act as a sphincter, with regard to the urethral orifice; it is called 'sphincter vesicae internus' (at point a, Fig. 7). Around the urethra just outside the bladder is a circular layer of striated muscle which is frequently designated as the external sphincter, or sphincter urethrae"—Am. Text Book Phys., 1896.

When the urine accumulates in the bladder, to prevent its escape the elasticity of the parts, aided by the tonic contraction of

when the operation was complete, showing that the sphincter vesicae internus has complete control of the urine, without the aid of the sphincter urethrae, notwithstanding the statements of so many authorities to the contrary.

"When the accumulation in the bladder becomes greater, the external sphincter is brought into action"—Am. Text-Book Phys., 1896. This we have been unable to observe, as the extensive operation interferes with this sphincter. If the desire to urinate is strong, the external sphincter is undoubtedly controlled by voluntary effort, but whether



or not in mature filling of the bladder it is brought into play by involuntary reflex, is not definitely determined. Emptying the bladder may be prevented, if desirable, when it is filled, by voluntary contraction of the sphincter urethrae. According to Goltz, the voluntary control of the process of micturation is limited to the action of the external sphincter and the abdominal muscles. The contraction of the bladder is an unconscious reflex, taking place through a lumbar center.

"The mechanism of closure of the bladder has been the subject of much discussion. Retention of urine has been variously as-

offered to the outflow of urine is occasioned at the vesico-urethral orifice, only a small part being offered by the urethra itself. Thus, in surgical operations, the urethra may be incised up to the neck of the bladder, without the escape of urine, and in the cat the urethra between the neck of the bladder and the prostate gland may be divided completely without any urine escaping.

Reyfish has excised the prostate in dogs without producing incontinence. Experiments show that the resistance to the outflow of urine, is situated at the neck of the bladder, and must be due either to tonic



Fig. V.

Shows the horseshoe shape of the prostatic urethra, also the elevation of the floor of the urethra into the crescentic anterior wall which covers four-fifths of the entire circumference of the urethra. The fibers of the prostate extend into the verumontanum.

cribed to the elastic resistance of the tissues at the neck of the bladder, or to the contraction of the external sphincter of Henle. Heidenhain and Colberg proved that the elasticity at the neck is not the only factor in closing the vesico-urethral orifice, as the bladder of the dead subject will not stand the same pressure as the living without leakage through the urethral orifice. If the lumbar spinal cord is disturbed, the condition in favor of the living animal is abolished, showing that it depends on the existence of the tonic contraction under the influence of this part of the cord. There is no doubt that the greater part of the resistance

contraction of the circular fibers at this point or to the elastic retraction of this orifice, aided, perhaps by the position of the mucous membrane along the whole length of the urethra. Great care must, therefore, be exercised, in any operation on the neck of the bladder, not to interfere with the zone of control in the act of micturation.

Not only is the sexual function diminished or lost by the removal of the prostate, but it is materially interfered with by prostatotomy, as in the Bottini operation. Guiteras says: "The patients are not always incapacitated for sexual life by the Bottini operation." From our observations, it

would appear that the prostate gland is placed over the neck of the bladder as a secondary muscular development. Its greatest bulk is made up of muscular tissue. It has situated within it a small glandular structure. The urinary control is entirely independent of the prostate, as has been shown in my cases; for, if the prostate was removed, the urine did not escape except in cases where the bladder wall had been torn in liberating or detaching the enlarged prostatic lobe. It is rather an accessory to the sexual function than to the urinary apparatus. G. Buckston Browne, says he believes: "That the prostate has no special urinary function whatsoever." W. H. Howell<sup>4</sup> says: "By careful experiments on white rats, Steinach has shown that the removal of the seminal vesicles and prostate gland, while not diminishing the sexual passion and the ability to perform the sexual act, including the actual discharge of spermatazoa, prevents entirely the fertilization of the ova. Removal of the seminal vesicles, alone, remarkably weakens the fertilizing power of the semen. The secretion of these accessory glands are essential to the mobility of the spermatazoa, and they may have other important functions." The function of the prostate is to contribute the prostatic fluid to the semen. The specific use of this fluid is not known. Erection without the prostate seems impossible.

#### ETIOLOGY.

Browne believes that we have no reliable data on which to base a theory of the prostatic enlargement. However, he says, when asked how to avoid the malady, "I would suggest plain living, exercise on foot, very moderate worship at the shrine of Venus after 50 years of age."

The age at which prostatic enlargement begins is variously estimated. L. Bolton Bangs<sup>5</sup> believes that it begins a considerable time before the 50th year, and that the earliest manifestations of prostatic hypertrophy are not generally recognized. Prostatic hypertrophy is extremely rare in Japan, India and China<sup>6</sup>, while in Turkey it is of comparatively frequent occurrence.

Schultze<sup>7</sup> states that enlargement of the prostate is rarely found in the negro, al-

though he describes one in which the middle lobe (obtained by autopsy) measured 5x7 c. m., and microscopic examination showed a marked hyperplasia.

We do not believe that excessive sexual indulgence plays any more part in enlargement of the prostate than in the production of fibroma of the uterus; and it is well known that, proportionately, fibromata of the uterus are more common in the unmarried than in the married. Then again, it is markedly absent in such races and nationalities as the Japanese, Chinese, Negroes and Indians.

Our exact knowledge of the etiology of enlargement of the prostate may be summed up by saying that "We know nothing definite about it."



Fig. VI.

Shows the tit-like projection of the middle lobe into the floor of the urethra.

#### PATHOLOGY.

Benign neoplasms and enlargements of the prostate resemble very closely in their histology, in their mode of development and in their relation to the organ itself, the non-malignant neoplasms of the uterus. First, they are: myomata, fibromata and combinations of these two, principally the combinations, and not infrequently there is a general hypertrophy of the entire gland, without any distinct tumor formation, resembling closely the soft, flabby, sub-involuted uterus (see Fig. XII, case 3). The enlargements are many times completely encapsulated, as shown in Figs. XVIII and XIX, case 7. In a great majority, however, they are closely connected with the prostatic tissue itself (see Fig. XVIII, case 7); just the same as in the intramural fibroid there is always

an enlargement and hypertrophy of the uterine tissue associated with myoma (see Right Lobe, Case 7, Fig. XVIII). In the lateral lobes, the tumors are more frequently intramural, as seen in Fig. XIX, case 7—next sub-mucous. In the middle lobe they are often pedunculated, rarely intra-mural, and practically never sub-capsular.

Wishard<sup>6</sup> draws particular attention to the mechanical part of the obstruction in hypertrophy of the prostate, and to the direction which the enlarged body takes, viz., towards the bladder, in the direction

that while it does not cure, it at least prepares the patient better for the operation. His treatment consists of strict dieting, assisted by urotropin in full doses, to render the urine alkaline (sodium phosphate would accomplish this much better), and the administration of kava kava, triticum repens and uva ursa, associated with daily rectal injections of hot saline solutions and sitz baths. However, when the operation is resorted to, he favors prostatectomy, either by supra-pubic or perineal route.

The development of forceful and scientific

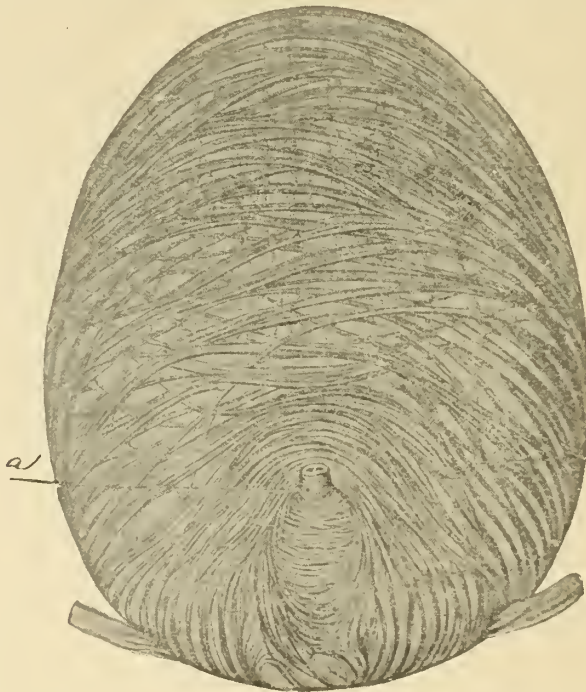


Fig. VII.

Shows the muscle fibers of the bladder and the sphincter vesicae internus (a) with the prostate removed.

of the urethra, or in the direction of the rectum, as the case may be. The size in one direction bears no particular relation to the size in the opposite direction. It interferes more or less with the urinary function, depending upon the direction of the pressure, whether it be upon the bladder, urethra or rectum, and the angle produced in the urethral canal.

#### MEDICAL TREATMENT.

James R. Hayden<sup>8</sup> strongly favors a conservative palliative treatment, and claims

procedures in the treatment of prostatic lesions has scarcely kept pace with the development of operative procedures in other fields of surgery. It has, however, though tardily, developed on the same lines with its analogous organ in the female, the uterus. Surgery of the prostate gland is now rapidly taking definite form on rational mechanic, anatomic and histologic bases.

During the last quarter of the century the sufferer presented a lamentable picture. Usually a man of great energy, strong men-



tality, physically robust, indefatigable in his labors, and by these qualities had gained a competence whereby he could spend his declining days in comfort and the pursuit of pleasure were it not for his prostate; by this he is deprived of his sleep, suffers intensely from pain, and sees no ray of hope for relief from his prostatic enlargement or its unpleasant sequences except in death. This picture may not fit the few, but it

of the urethra anterior to the prostate. There is no such condition as prostatic stricture. The urethra is always patent in its prostatic portion, and the obstruction offered to the passage of the catheter is the obstruction due to deformity, poekets, prostatic sinuses and compression of the urethra by encroachments on its lumen from various directions by the enlargements or neoplasms in the prostate itself, as shown in schematic



Fig. VIII.

Shows the hook retractors applied to the prostate.

does fit the many, who suffer to a pathologic degree from prostatic enlargement.

Temporary catheterization is resorted to for the relief of urinary retention, which comes on after some undue exposure, acute illness or traumatism, or what not which produces a temporary retention. This should be accomplished with all aseptic precautions, with the greatest gentleness in mechanical manipulation. It can always be accomplished where there is absence of stricture

drawing Fig. IX. All of these occur on the posterior and lateral portions of the urethra; the anterior portion offers no obstruction. The ideal course of the catheter, therefore, is along the anterior wall of the urethra. It is only a question of proper manipulation and an estimate of the directions of the canal for the successful accomplishment of temporary catheterization. In this, force must play no part. *It should and can always be accomplished by those of skill*

and experience in primary urinary retention, and the patient is, therefore, never forced to an immediate operation on his prostate under these circumstances, because he is then often in an unfavorable condition for operative procedure. The soft rubber, with or without the lead stilet, and the Coudee catheter, preferably of large size, are the best instruments to use. In these primary retentions the bladder may be completely emptied without danger.

Continued or chronic retention presents to the surgeon many distinctly different, as well as dangerous phases. Under these circumstances the bladder is often enormously

#### PROSTATOTOMY (BOTTINI).

Ramon Guiteras<sup>9</sup> may be said at present to favor prostatectomy but he admits that a large portion of the cases are in such condition that no radical operation is justified. The Bottini operation in his hands has afforded this class of patients great relief. He has made a thorough investigation<sup>10</sup> of the Bottini operation and comes to the following conclusions: "It is difficult to conceive why an operation consisting simply in burning linear scars into the sides and floor of the prostate gland and followed by the casting off of sloughs, should cause such a reduction of the urinary obstruction, and

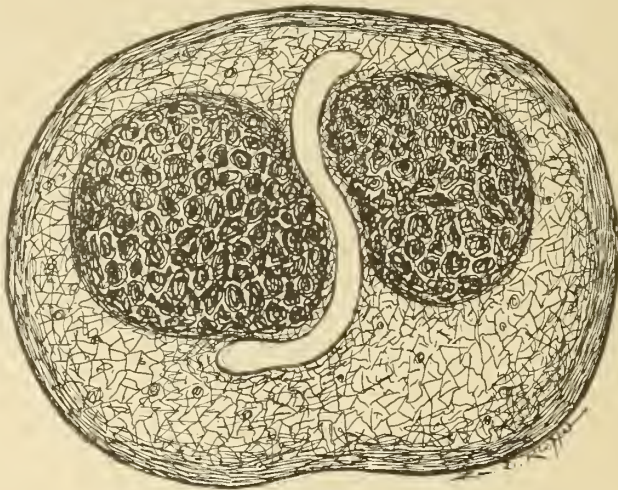


Fig. IX.

Shows the changes in the shape of the urethra produced by myomata.

enlarged; its veins are compressed, its walls anemic from pressure; its arteries are frequently dilated and advanced pelvic or peripheral renal changes may have taken place. Because of this protracted compression of the combined urinary surfaces, care must be exercised that this pressure is not too suddenly relieved, i. e., that the bladder is not completely emptied; otherwise, we have found by experience that there is an immediate congestion of the urinary surfaces often followed by hemorrhage, frequently by shock, chills, fever and death. A chronic sufferer from vesical distension should never have his bladder completely emptied in a primary catheterization.

such a contraction of the gland; clinical evidence, however, supports the truth of this statement." Incontinence of urine is rare after prostatectomy (Bottini). The cure of incontinence is not due to increased strength in the vesical sphincters, but to relief of the over-distended bladder, as the pre-operative incontinence in the sufferer is due to over-distension rather than lack of sphincteric tone.

There can be no doubt there is an immediate relief of the urinary retention and its most distressing sequences by the Bottini operation in properly selected cases.

Hugh H. Young's experience with the Bottini operation covers 40 cases<sup>11</sup>. Six

were lost sight of; 34 operations were performed on 31 patients, three patients having each two operations; the ages of these patients averaged very high, eighteen being over 67 years; of fifteen over 70 years of age, all are alive and well; three of the 31 died, two of these four and five weeks after the operation, from uremia; one from sepsis from a peri-prostatic abscess due to a 4.5 centimeter incision puncturing the capsule. In all there was an immediate relief of the urinary retention. Of twenty cases which were operated on a sufficient length of time to admit of deductions as to the result, 17 were cured, two improved and one unimproved. Of the eight others, the conditions were good up to the present time. All dispensed with the use of the catheter.

Dr. Bangs<sup>12</sup> in commenting on his results with the Bottini operation, says that 60 per cent of the subjects threw away the catheter; about 20 per cent have an increased amount of spontaneous urination; and 20 per cent received little or no benefit. He secures special advantages by the use of his solid tip metal catheter after the Bottini operation. In the 40 cases he reports, there were three deaths *directly attributable to the operation*. Two of these were from sepsis and one from shock. Notwithstanding these apparently favorable results<sup>13</sup>, he pronounces the operation a serious one, and not to be lightly undertaken; that the danger is in proportion to the severity of the procedure; that the symptoms immediately following the Bottini operation are, frequent urination, with considerable pain; hemorrhage, either primary or secondary (in about one-third of the cases); fever in 30 per cent. and chills in 20 per cent.; and that the post-operative period, in which these symptoms are present, continues for from two to three weeks. Incontinence, an annoying symptom, was present in 6 per cent.; 9 per cent. were operated on twice, and 2 per cent. of these were not benefited by the secondary operation; in 20 per cent. there was no benefit. Guiteras<sup>14</sup> collected 753 prostatectomies; 622 were cured (85.5 per cent.); 44 died (5.8 per cent.); 87 were failures (11.5 per cent). J. W. S. Gouley<sup>5</sup> concludes that the Bottini operation has no advantages over

the Mercier operation, which he introduced into this country in 1878, and has performed fifteen times. He believes that the operation of prostatectomy is the one indicated where the prostate is enlarged, whether soft or hard. S. Alexander<sup>5</sup> considers that the technic of the prostatectomy bearing his name is a most dangerous and difficult one, and he is disposed to discuss its failures rather than its successes. He considers the Bottini operation favorable in selected cases, and wishes to impress upon its adherents that the obstruction in prostatic hypertrophy is not intra-vesical, and, therefore, could not be observed with the cystoscope or searcher. Willy Meyer<sup>5</sup> believes that the width as well as the depth of the incision in the Bottini operation is important. He uses permanent Mercier catheter after the operation, and keeps the urine loaded with antiseptics. He considers that prostatectomy is the more surgical procedure and that the after treatment is much less difficult and arduous than after the Bottini operation. He also considers the soft prostate difficult to cure by prostatectomy.

The destruction of the prostate was accomplished by me a few times at the Alexian Brothers' Hospital by means of thermocautery through the supra-pubic route, with a vaginal rubber speculum inserted into the bladder, but the average results were not such as to encourage me in continuing the work, and I have abandoned it for perineal prostatectomy.

#### PROSTATECTOMY.

It is gratifying to note the advances that have been made by the medical profession in the operative treatment of prostatic enlargement in very recent times. Even so modern a man as Sir Henry Thompson said that he did not believe it was possible to operate on a case of enlarged prostate and have a result that would permit him to discontinue his catheter and still be able to empty his bladder and retain his urine. Now, we know that these results are of daily occurrence.

The indications for prostatectomy are: 1, prostatic enlargement to a pathologic degree, i. e., sufficient to prevent urination or cause large residual retention; 2, painful and fre-



quent micturation; 3, cure for catheter life; 4, cure for secondary cystitis; 5, for the relief of pressure on the rectum.

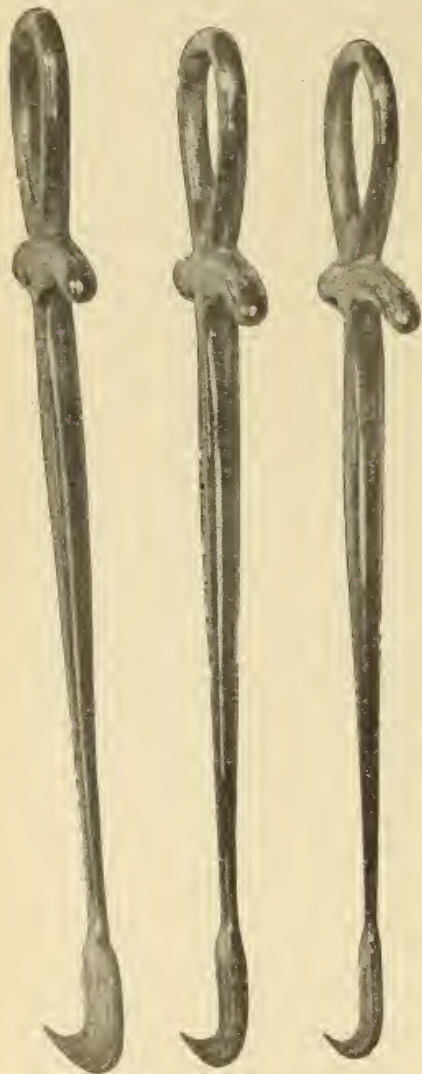


Fig. X.

Retraction hooks for drawing down the prostate.

It should be the operation of election where the patient is in condition to withstand the operative procedure and the local general conditions are favorable. The operation should not be considered nor used as a last resort. Local or spinal anesthesia should be preferred in selected cases.

#### SUPRA-PUBIC PROSTATECTOMY.

William T. Belfield of Chicago deserves the honor of being the first to follow a deliberate plan for the removal of the middle

lobe through a supra-pubic incision. This was not an accident, as suggested by Mr. G. Buckston Browne, but was a deliberately planned and executed operation, as was well known to many of the Chicago profession at that time; the honor is incontrovertibly his, while Dittle's operation was not deliberately planned and executed, but was done in an emergency. Mr. A. F. McGill laid down more definite indications and lines of procedure three years after Belfield's original work, although we believe that it can be said that McGill had no knowledge of the Chicago surgeon's technic at the time he performed his first operation.

The supra-pubic route was the one uniformly followed in my ten years' service at the Alexian Brothers' Hospital. Either enucleation or cauterization was accomplished through a supra-pubic opening, by the aid of curved scissors, Kocher dissector, volsella forceps and the index finger. The middle lobe was readily and easily enucleated, but the enucleation of the lateral lobes through the supra-pubic route was always a difficult, bloody, dark and unsatisfactory procedure, though many times gratifying in its relief to the patient. In this technic there is practically no danger of opening the peritoneum, as the base of the prostate is situated fully half of the length of the bladder below the most dependent portion of the vesico-rectal folds, and is very movable at that point. There is danger, however, of lacerating the rectum.

Charles H. Mayo favors the supra-pubic enucleation of very large, middle and lateral lobes, and believes that the technic is more simple and results more favorable by this procedure, using supra-pubic or supra-pubic and perineal drainage, according to individual indications.

Proust<sup>15</sup> describes an elaborate technic for a sub-total prostatectomy with subsequent suture of the pedicles. The vasa deferentia and the slit in the urethra are also closed, while a catheter is left in place. The suturing of the vasa deferentia or seminal vesicles would seem to us a difficult task. Mr. P. F. Freyer<sup>16</sup> commenting on injury to the seminal vesicles, considers that it is a matter of little importance what becomes of

the ducts, and pays no attention to them. In speaking of hemorrhage, he claims in supra-pubic operations that when the gland is enucleated from the capsule there is little hemorrhage.

Mayo-Robson, years ago (1887-1894) enucleated and excised large masses of the prostate suprapubically, with very satisfactory results. The original operation of enucleation, however, he desires, through a personal letter to me, to be credited to Mr. Leonard Atkinson, to whom he says is due the credit of the first enucleation of myomata of the prostate. Mayo-Robson, in his able article, has left the stamp of his genius on this, as well as on all other branches of surgery to which he has devoted his attention.

Ramon Guiteras<sup>14</sup> collected 153 prostatectomies. Of these, 110 recovered, 72.3 per cent.; 25 died 16.4 per cent.; 17 were failures, 11.2 per cent.; and he concludes that the results in those that recover from prostatectomy are better and more permanent than those following prostatotomy. He believes, however, that great care and judgment must be used in the selection of cases, and submits the general rule that "the large glands are favorable for enucleation and the small ones are best treated by prostatotomy; and if the kidney be diseased, either medically or surgically, the Bottini should be resorted to."

Eugene Fuller<sup>17</sup> favors the supra-pubic route for the large prostates, and believes that the operation of enucleation can be performed cleaner and safer in that way; but, where the bladder wall is hypertrophied, he considers it much easier and safer to use the perineal operation.

From the fifteen cases of supra-pubic prostatectomy reported by Hugh H. Young<sup>11</sup>, there were two deaths, neither of which, however, could be attributed to the operation. The ultimate results from the supra-pubic operation were very favorable. In this number he classes 11 as "complete enucleation of the prostate." (I believe, however, he means enucleation of the lateral and posterior lobes and not a complete prostatectomy.) Ten of the fifteen were

classed as cures and two still suffer from cystitis.

W. Floyd McRae<sup>11</sup> strongly favors the supra-pubic operation, and reports three successful cases. He considers that there are special advantages in his ingenious "parachute" drainage method. One of his operations was on a case previously treated by the Bottini plan.

Harold L. Barnard<sup>18</sup> thinks that the success following enucleation of the prostate for adenomatous hypertrophy, which he considers the most suitable type, is not equaled by any other method of treatment, although he prefers the supra-pubic method.

William N. Wishard<sup>6</sup> strongly favors the supra-pubic Belfield-McGill operation, as modified by Fuller and Alexander. He believes it is the most direct means of attack, and gives the best results, as expressed in the following: "If the supra-pubic operation has been thoroughly done, and all obstruction removed, the patients afterwards are assured of more perfect function than by any other method." He thus expresses himself concerning the perineal operation: "The operation may be regarded as limited to drainage operations and to small pedunculated growths, and to the division of collar-shaped enlargements of small size."

#### PERINEAL PROSTATECTOMY.

Parker Syme<sup>19</sup> prefers the perineal route, because it appears to him the most direct. He believes that the median perineal incision should be made, and considers that he derived great advantage from his prostatic retractor in the twelve cases in which he used it. He favors the removal of the left lobe first, the middle lobe second and the right lobe last, and the use of a steel sound every third day after the operation. He forcibly advocates early operation. He operated on 9 cases; all recovered; in 8 there was complete restoration of function.

J. W. S. Gouley<sup>20</sup> favors the perineal route. The retractors of Gouley appear to have advantages, although I have not used them, as the hooks are so much more readily applied.

John A. Wyeth<sup>22</sup> believes the perineal operation the one of choice. Dr. Alexander agrees in this view, but makes the supra-

pubic incision so that he may force the prostate into the perineum. This is not necessary where the hooks are used, and the capsule and deep perineal fascia properly divided. Most of Dr. Alexander's patients were out of bed in five or six days. No aged patient, after any operation, should be allowed to lie flat on his back. He should be placed in a sitting position immediately, should occupy the recumbent position at night, and should be out of bed as early as the fourth or fifth day.

Alexander Hugh Ferguson<sup>11</sup> reported six cases at the Atlanta meeting, in which he removed the prostate by morcellement. He claims advantages for this method, and has

#### TECHNIC OF THE PERINEAL OPERATION.

The crescent shaped, or "A" shaped incision may be used. I now use the latter exclusively. I first divide the skin and superficial fascia down to the inner margin of the ischio-cavernosus; the handle of the scalpel is used to separate this muscle from the bulbo-cavernosus, and to split the fibers of the transversus perinei parallel to their long axis, until the handle of the scalpel reaches the capsule of the prostate. The same procedure is followed on the opposite side, then the finger of the left hand is inserted into the rectum and the median raphe is divided transversely with the scalpel until the prostate is reached. The

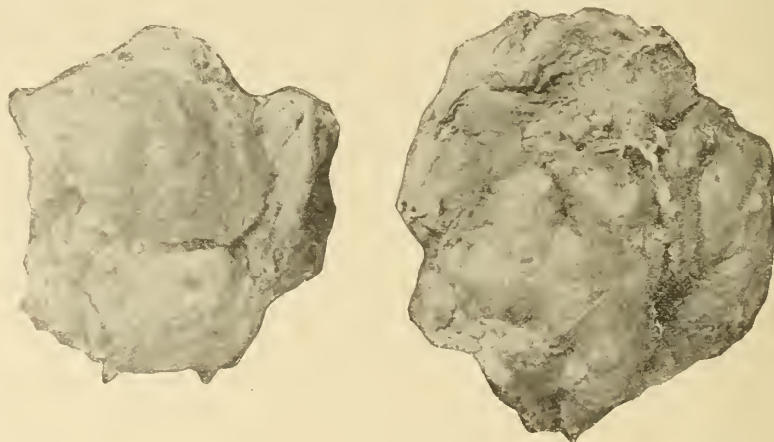


Fig. XI.  
Shows photograph of prostate from Case II, reduced one-half.

a prostatic forceps so constructed as to "bite" out fragments of the prostate without danger of injury to the surrounding parts; he also has an intra-vesical depressor which he believes adds much to the ease with which the operation is performed. His six patients made good recoveries. He also calls them complete prostatectomies, while I believe he means lateral and posterior prostatectomy, allowing the portion of the prostate known as the "isthmus" anterior to the urethra to remain.

James Bell<sup>23</sup> beautifully illustrates with a case, a type of prostatic enlargement in which the Bottini operation would have served no purpose, and in which prostatectomy produced an ideal result.

Charles Whallen<sup>24</sup> favors spinal anesthesia for prostatectomy.

capsule of the prostate is then divided clear across its presenting face, and the capsule and bladder are peeled backward to the base of the prostate; then a Sims speculum is inserted and the prostate is enucleated by pulling it forward with the hooks and separating it from the bladder from behind forward until the apex of the prostate is reached and divided with scissors it is then torn away from the middle line posteriorly. The right lobe is removed in a similar manner. Then the urethra is opened and the middle lobe enucleated and stones in the bladder removed. The redundant portion of the prostatic urethra is now cut off with the scissors and the opening sutured down to the space for the drainage tube. Perineum is packed with subiodide of bismuth gauze, and the skin is sutured down to the



drain as accurately as if it were an operation on the face.

By the perineal operation the wall of the bladder should not be divided nor torn, but the posterior wall of the prostatic urethra should be removed. The urethra should never be opened primarily, and the prostate should never be shelled away from the bladder from before backwards, but always from behind forwards, dividing the isthmus as the prostate rolls off from the bladder. To favor this, I have used, with the ordinary deep lateral retractors and Sims speculum as a posterior retractor, the hooks shown in Figs. X and XI. The hooks are utilized; 1, to draw the prostate into the field and retain it there; 2, to evert the prostate while it is being detached from above downward from the bladder wall. I find great advantage in using the handle of the scalpel down to the prostate on each side before dividing the septum. It insures safety to the rectum.

It is entirely unnecessary in the operation of prostatectomy to remove the whole anatomical structure, as is claimed by Freyer<sup>18</sup>, as the anterior portion of the prostate, or isthmus, never shows any material encroachment and never produces urinary obstruction. It can, however, be as easily removed, if the entire enucleation be desirable, by the perineal route as by the supra-pubic, if the hook retractors be used as in the drawing. The hemorrhage is very much less by the perineal than by the supra-pubic route.

#### REMARKS.

The results have been more gratifying as time progressed and we became more familiar with the technic in the more complicated and difficult cases; but my first case has not been excelled by any subsequent case.

There are two cases of fistula of the urethra; in one of these there was an abscess of the prostate that had ruptured into the rectum a short time before the prostatectomy. It was not determined whether this case was tuberculous or not. In this case the rectum wall was adherent to the major portion of the wall of an enlarged prostate and great care had to be exercised to avoid injury of the rectal wall.

The capsule of the prostate should be displaced backwards with the rectum, to insure the integrity of the rectal wall.

The hemorrhage was quite profuse in two cases. This was controlled by placing haemostatic forceps on the bleeding points, which were allowed to remain for forty-eight hours, as in vaginal hysterectomy. The gauze packing with subiodide of bismuth is sufficient to control venous hemorrhage.

The permanent urethral catheter has been abandoned in my later cases. It is not only unnecessary, but injurious. The perineal drain is retained until the urine is practically free from pus, usually in five to eight days it is removed. The bladder was not irrigated.

It is important to remove the redundant prostatic urethra, to avoid the tendency to perineal fistula; and the opening should be closed with catgut sutures, down to the drainage tube.

#### CONCLUSIONS.

(1) The perineal route gives the best ultimate results.

(2) It is accompanied by less danger than the supra-pubic or Bottini operations, as: (a) In hemorrhage; (b) sepsis; (c) injury to the neighboring structures; (d) less danger to life.

(3) The drainage is excellent, and favors rapid restoration of the bladder to its normal condition.

(4) The period of wound repair is much shorter than by the supra-pubic route. All the cases had primary union down to the drainage tube.

(5) The vesical control is almost uniformly good.

(6) The sexual power is destroyed.

(7) The relief of vesical irritation is great, and the frequency of urination is reduced to about normal.

CASE 1.—Mr. E. W. W., aged 55; occupation, financier; was referred by Drs. Henry Hooper and Archibald MacLaren. He was admitted to Mercy Hospital May 16, 1901, and operated on May 18, 1901. He was discharged June 26, 1901. Family history was negative.

Personal history: He has had specific urethritis; stricture followed; cured.

Present illness: Three years ago he began to suffer from increased nocturnal micturition, not associated with pain. This continued increasing in frequency and rest at night was much disturbed; then the frequency of urination in daytime became markedly increased. Finally, about two years ago, the catheter was first resorted to, which was used only every second or third day in the beginning. The vesical irritation, however, became greater and the quantity of pus in the urine increased until daily vesical lavage was resorted to by the attending physician, the catheter being used several times a day for the relief of urinary retention. A portion of the urine could be voided by strained efforts leaving about three ounces of residual urine. These symptoms continued up to time patient was admitted to the hospital. He was entirely incapacitated for work.

Examination: Urine examined shows a trace of albumin, some blood and a large amount of pus. Urea, 1.8 per cent.; sp. gravity, 1024. With difficulty a sound was introduced into the bladder. Prostate was very much enlarged; left lobe largest, median lobe pressed markedly forward. Patient is emaciated and very neurotic.

Operation, May 18, 1902. Perineal prostatectomy performed. Hook retractors used to draw prostate down. Ferguson's prostate staff introduced into bladder. Fuller's semilunar incision in perineum, through perineal tissues up to membranous urethra, extending laterally to rami and from lower margin of scrotum in center to level of anus at external ends. The two lateral lobes were removed first, then two small median lobes were shelled out after the lateral lobes were removed. Tube placed in bladder through perineal opening and soft rubber catheter inserted through penis; cavity packed with gauze.

Patient returned from operating room, pulse 82, complained of some smarting pain; was placed in a semi-sitting position, 40 degrees.

May 19: Pulse was 96, temperature 99.6. Patient rested fairly well during night;

May 20: Pulse 90, temperature 100; rested fairly well. Good drainage through both catheter and perineal tube.

May 28: Pulse 88; temperature normal since May 20. Urine passed through tube 715 c.c., alkaline, sp. gravity 1015, cloudy; few hyaline casts, round, oval and spindle cells. Pus cells numerous; bacteria present. May 29: Pulse 88, temperature 98.2. Tube became obstructed and catheter also; latter was removed.

June 1: Pulse 98, temperature 100. Considerable pain in lumbar region. Tube removed and permanent catheter inserted. Patient has a mild pleuritic friction sound. June 4: Pulse 86, temperature 98.6. June 7: Pulse 80, temperature 98.6.

June 9: First voluntary urination through urethra; the day following practically all urine passed through this channel; full control, and painless. Patient is doing well; sitting up. June 17: Pulse 76, temperature 98.6. Patient is sitting up daily; 1320 c.c. urine voided in last 24 hours. Perineal wound healed. June 23: Pulse 78, temperature 98.6; patient went for a drive; feeling well. Amount of urine collected in 24 hours, 1375 c.c.

June 26: Pulse and temperature normal. Patient was discharged feeling well; has good control over bladder; urinates every two to four hours in daytime, but is not disturbed at night; no residual urine. Urine: sp. gravity 1005; urea .9 per cent.; no albumin; granular renal cells; few pus corpuscles. Not the slightest pain in urination.

February 4, 1902: Patient has perfect urinary control; can sleep the entire night without urinating. He says his urinary apparatus feels like it did when he was a boy.

In a letter received from this patient, February 25, 1903, he states that the perineal wound has remained closed and that he has complete control over the bladder. He holds his urine five or six hours during the day and is not obliged to get up to urinate during the night. Never has any pain in the wound, bladder or urethra and the urine is free from pus. Sexual function is markedly impaired. His general

health is excellent, his weight is normal and he says that his ability to attend to his business and enjoy life was never better.

CASE 2.—Mr. J. S., married, aged 54, merchant, was sick seven years; diagnosis of prostatic hypertrophy.

He was admitted to Mercy Hospital July 3, 1901, and operated on July 13.

Family history: Father died of tumor in throat in 1861. Personal history: Patient was born in Germany, but lived 44 years in America. General health was always good; appetite good, bowels regular.

Past illnesses: He had an infection in arm when 16 years old, and has running sore at present as result of same; chronic dysentery in 1865.

Present illness: For past seven years patient has been troubled with painful urination and inability to empty bladder. For past five years there were times when patient could urinate quite freely, but cold or exposure would make it extremely difficult. Two years ago he began catheter life, continuing it for thirteen months. He then received some electric treatment and dispensed with the catheter, although urination was very difficult and painful. Early this spring the symptoms increased in severity. He resorted again to the catheter, passed considerable pure blood at times. Patient states that as far back as seventeen years his bladder has been weak, and he did not have proper power of expulsion; has suffered extremely in an effort to abandon the catheter, using it but once in three weeks. The prostate is very much enlarged and almost fills the pelvis.

July 12: Chemical examination reveals a trace of albumin. Microscopic examination shows pus in quantity. Residual urine  $3\frac{1}{2}$  ounces.

July 13: Operation perineal prostatectomy. Ferguson sound introduced into bladder and held in position throughout operation. Two lateral and one middle lobe were removed. Large rubber drainage tube inserted into bladder. Wound packed with gauze; permanent catheter inserted through penis into bladder. There was considerable hemorrhage from the left side, which was

controlled by a 6-inch hemostatic, which remained for twenty-four hours.

Patient returned from operating room in good condition; pulse 104, tempt. 97.4; strychnia sulph. and spts. amm. arom. were the only medication. (See Fig. XI, case 2.)

July 15: Tempt. 100.8, pulse 90, sixty hours after operation, then normal until July 26. Occasionally an infusion of tritium with cathartics sufficient to keep bowels open, and general diet. July 23: Perineal drain removed. July 25: Catheter removed. August 1: Tempt. 102, pulse 120; patient in great pain, caused by a mild epididymitis.

August 3: Tempt. dropped to 99.2, pulse to 100. Patient passed some urine through urethra. Aug. 9: Passing all urine through urethra and can hold it as long as two hours. Perineal wound closed. Aug. 12: Tempt. 99, pulse 100. Night sweats. Amount of urine, 700 c.c. Sp. gravity, 1017; urea 2 per cent.; trace albumin. Some squamous epithelium; some pus cells. Testicle still painful and somewhat swollen. Aug. 18: Tempt. normal, pulse 80.

August 22: Patient is discharged, with full control of urine and practically no pain in urination; R. H. Foster of Le Mars, Ia., reports as follows, Jan. 30, 1902: "The muscular fibers of the bladder have completely regained their lost tone, and he can propel the stream to a normal distance. The frequency of micturition, especially at night, has disappeared to such an extent that during the past three months he has not had any call to get up at night except while suffering from the orchitic attack, which I mentioned to you in my former letter. The power of retention has returned to a normal condition; also the lumen of the stream, which is remarkably full in volume and is neither flattened, forked or twisted."

In a report received from this patient, March 30, 1903, he states that the wound has remained entirely healed; he has complete control over his bladder and can retain his urine as long as he desires, never having to get up at night. He has not used catheter since the operation. He has no pain in the wound, but has slight feeling of contraction at the close of the act of mic-



turation. There is no blood or pus in the urine, but slight amount of mucus. Sexual function is wholly absent. His weight is normal, appetite good and he can follow the active pursuits of life with pleasure.

CASE 3.—Mr. A. J., aged 67, merchant, was sick 2 years. He was admitted to Mercy Hospital Aug. 24, 1901, with diagnosis of prostatic hypertrophy and cystic calculi. Family history is negative. Personal history: Suffered severely from constipation. Past illnesses: He had malaria in 1860, and sciatica at intervals for past ten years.

Present illness: Began two years ago with frequent desire to urinate and vesical tenesmus; burning in perineum, hypogastrium and glans penis, which was relieved on urinating. Patient has been compelled to use catheter at intervals for past nine months. Three months ago a few drops of blood appeared at the end of urination. In the past few weeks patient has suffered severely from vesical spasm, which was not relieved by emptying the bladder. The prostate is very much enlarged. Stone detected.

August 24: Reaction of urine acid; sp. gravity 1013, small amount albumin; urea 1.4 per cent. Microscopic; epithelium, a few squamous cells; many red blood cells; pus in quantity. Residual urine 10 drams.

August 25: Operation. Perineal prostatectomy performed volsella forceps used to draw down the prostate. Forceps introduced into bladder and stone removed without difficulty. Rubber catheter introduced through urethra into bladder and secured. Large rubber tube introduced in the bladder through perineum and perineal wound packed with subiodid bismuth gauze, to suppress the oozing. Deep sutures of catgut used to bring structures into apposition. Interrupted silkworm gut sutures for partial closure of incision.

Patient returned from operating room in good condition. After nausea had ceased he was put on urotropin, 7 grains, t.i.d.; liquid diet.

August 27: Patient rested well; pulse 102, tempt. 101. Wound dressed; some oozing; bladder irrigated with solution of

boric acid. Aug. 28: Pulse 80, tempt. 100; patient had some pain; wound dressed. Urine in bottle 720 c.c. Considerable urine lost on dressings. Aug. 29: Drainage free; patient easy; 900 c.c. urine. Aug. 30: Pulse 88; tempt. 98.8. Urine 1000 c.c. through tube.

August 31: Pulse 88, tempt. 99; patient delirious short time. Amount of urine 2000 c.c.; reaction acid; sp. gravity 1015; turbid; urea 2.4 per cent.; albumin in quantity. Small squamous epithelial cells; few red blood corpuscles. Considerable pus; bacteria present.

September 1: Pulse 84, temperature 98.8. Patient rational; suffering pain and stinging sensation. Sept. 4: Wound looks healthy. Pulse 80, temperature 99.6. Sept. 10: Pulse 78, temperature 98. Perineal sutures removed. Sept. 12: Pulse 70, temperature 100; perineal wound closing rapidly and looks healthy. Sept. 14: Patient had chill. Pulse 88, temperature 102. Syphon attached to catheter.

September 15: Pulse 80, temperature 98.8. Right testicle swollen, tender and painful; left epididymis indurated, which accounts for chill yesterday. Applications of ice. Scrotum suspended. Sept. 16: Pulse 78, temperature 99. Urotropin, grains 5, t.i.d. Swelling in testicle reduced. Urine examination: Sp. gravity 1015, clear; urea 2.2 per cent.; numerous pus cells, otherwise normal. Sept. 22: Pulse 78, temperature 100; patient rested well. Urine ceased to pass through perineal wound, allowed up daily. Nov. 7: Pulse 72, temperature 99; some pain but has partial control of urine.

From Nov. 7th to Dec. 19th, temperature remained normal. He had control of the urine, but could not hold it long without having a good deal of distress in the bladder. Dec. 3d: Permanent catheter inserted through the urethra, because of the frequent urinations and pain attending them. Bladder drained through catheter that day, but on Dec. 4th, catheter ceased to drain and the urine was passed through the urethra around it. Catheter removed on the 4th. Pain and frequent urinations continued with only short intervals of relief until Dec. 19, when it was decided to make a second peri-

neal section, to evacuate a small abscess which had formed in the perineum, and at the same time examine the condition of the deep urethra, and if possible determine the cause of the pain and frequent urinations.

Operation, Dec. 19, 1901: Median incision in the perineum an inch and a half long, with sound in the urethra. Small peri-urethral abscess evacuated. Urethra opened on sound, and finger passed through vesical neck, into bladder. No stone found in the bladder and no pocketing of the urethra. Wound packed with bismuth subiodide gauze. After operation, patient's temperature remained normal and he continued to suffer considerable pain in the perineum. From Dec. 20th to 25th, P. M.

It was noted that most of the urine was passing through the perineum, and only a small portion through the urethra. Pain in bladder and perineum was not now so severe as previously, until January 13th, when he began to have attacks of severe pain, which seemed to be caused by filling up of the bladder. Perineal wound remained open, but contracted to a small sinus, through which a little pus and urine escaped during micturation. On Jan. 25th, 1902, a third perineal section was performed and a *phosphatic* concretion removed from the bladder. Permanent catheter introduced through the urethra and perineal wound closed with silk-worm gut sutures, without drainage. On the evening of the

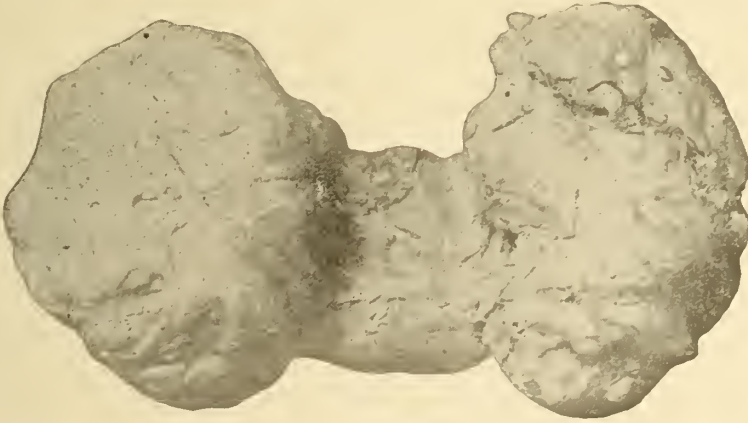


Fig. XII.

Shows lobes attached to each other. Reduced one-half.

temperature ranged from 100 to 104 F. During this time urine was passed through urethra and incision, with considerable pain. Perineal packing removed from wound Dec. 23. From this date to Dec. 25th, temperature remained normal. Perineal wound continued to discharge pus and urine when bladder was emptied, and pain in this situation continued. Pus discharge was very slight December 30, but urine continued to be discharged in this way. Dec. 31: It was noted that very much more urine was discharged through urethra during the night than during the day. January 4, catheter was passed into the bladder and two ounces of boric acid solution injected. After withdrawal of the catheter, all of the fluid escaped through the urethra. January 5:

operation, temperature was 101, but after the first twelve hours it did not go above normal. Permanent catheter removed Jan. 30th, at which time perineal wound had entirely closed. Feb. 7th: A small amount of urine was leaking through perineum, most of it being passed through the urethra. On Feb. 11th, most of the urine was passing through the perineum. When perineal wound was closed by pressure, he could retain urine forty-five minutes. March 3: Small white calculus the size of a split pea, was voided through the urethra. March 21: permanent catheter introduced into bladder and kept in for twenty-four hours. Another permanent catheter introduced April 7th, and retained until the 10th. Perineal wound still discharging some urine. On May 12th,

an attempt was made to close the perineal opening by dissecting out the fistula and bringing the tissues into apposition. Bladder drained through permanent catheter for three days. On May 15th it was noted that perineal wound had entirely closed, and that patient had good control of urine through the urethra. On the 16th, wound still closed, control not so good. On June 20th, perineal opening permanently closed. Large sized catheter passed without difficulty into bladder through urethra. Patient discharged from hospital with wound closed and fair control of bladder June 26, 1902.

In a report received from this patient February, 1903, he states that the perineal wound has remained entirely closed. He has not complete control of the urine, and there is leakage through the urethra when he moves about. At night there is considerable leakage from the urethra. He complains of considerable pain in the bladder and rectum, most of the time. Urine contains pus. Sexual function is entirely abolished. Believe there is another stone in the bladder and he is to return to Chicago.

CASE 4.—Mr. W. S. M., aged 58, married, farmer, was sick 8 years. He was admitted to Mercy Hospital Nov. 4, 1901.

Family history: Father died of rheumatism and heart complications at the age of 49 years. Mother died of Bright's disease at the age of 68. One sister died of throat and lung trouble, probably tubercular.

Personal history: Always moderate user of whiskey. Beer always seemed to aggravate present trouble. About nine years ago began to get up to urinate at night, but for last three or four years has been getting up three or four times; would pass small amount of urine each time. During first few years of the trouble urine showed heavy brick-red deposit on standing, but of late years has been clearer, with more offensive odor. Past sickness: Has had a right side inguinal hernia since 21 years of age; has had hemorrhoids for many years, but they have been worse since present trouble began, due to constant straining on urination.

Present illness: Patient was thrown from a horse and fell astride a ridge of dirt in the road, eight years ago. There was con-

siderable tenderness in the perineal region after this injury. Skin was not broken, but parts were bruised. He was put to bed; had chills and fever for next twenty-four hours. He only remained in bed for a day or so and passed his urine, at the time, with effort. There was no blood in urine, nor in stools. Since that time he has been troubled almost constantly with bladder trouble. There has been vesical tenesmus when on feet; if in bed he can hold urine longer. Patient can start flow of urine without much pain, but at the end of the act there is a dull burning and a dribbling for some time. When trying to hold urine any length of time there is a sudden loss of half an ounce or so before he can control it. For a long time patient has had a cutting pain in end of penis when through urinating. The straining at the end of urination brings down a small tumor mass in the rectum not unlike a hemorrhoid. All of above symptoms have been getting worse for past four or five months. He was catheterized but once, and that last summer, by a home physician, to see if there was retention of urine. He never has had any chills or fever since injury, eight years ago. Patient has never been confined to bed, but has never been able to work; for, as soon as he walks or rides, he has the desire to urinate, with the pain following. State of nutrition good; appetite good; bowels constipated. Examination: Prostate enlarged to second degree; stone detected behind the prostate.

November 6, 1901: The patient was prepared for operation in the usual manner: Technic same as in previous cases, except the staff was dispensed with after the capsule was exposed, and the prostate drawn forward with the hooks shown in Fig. VIII. The hooks were found of great assistance, as they permitted an easy separation of the base of the prostate from the bladder, and rendered the staff needless. The stone was extracted after the removal of middle lobe.

November 6: Nothing to record but an intermittent pulse, which quickly responded to strychnia. The highest temperature and pulse rate were 101.4 and 104 respectively. Nov. 7: Patient rested well; complained of some pain in bladder. Average temperature



and pulse same as previous day. Nov. 10: Patient resting well. Temperature 99.6, pulse 89; urine 600 c.c. through tube. Nov. 11: Temperature 98.8, pulse 93; wound dressed with dry dressing; saline cathartics. Urine 690 c.c.

November 12: Temperature 100.8; pulse 99. Patient resting well; packing removed; no pus; catheter irrigation; all drainage found free; scrotum somewhat edematous; left testicle enlarged and tender; right slightly enlarged.

November 13: Temperature 101.5, pulse 97. Bladder irrigated. Perineal drain removed Nov. 14: Temperature 99, pulse 82. Drainage free; urine 900 c.c. Nov. 15: Temperature 98.6, pulse 83; resting. Urine 100 c.c. through catheter. Nov. 16: Temperature 98.9, pulse 81; patient perfectly easy; urine 2160 c.c. Nov. 17: Temperature 99, pulse 76. Resting. Catheter removed.

November 20: All urine passed through urethra. Perineal wound practically closed. Dec. 4: No vesical pain; he can hold urine four to six hours, and does not have to get up at night. Microscope reveals small number of pus corpuscles in urine.

In a letter received from this patient Jan. 30, 1903, he states that the perineal wound has remained entirely healed since the operation. He holds his urine about three hours during the day and for the same length of time during the night. Has slight burning pain in the wound at intervals; also a little pain in the bladder. This latter pain is getting better all the time. Sexual function is entirely abolished.

Patient says that his ability to attend to business and enjoy life is better than for many years.

CASE 5.—Mr. P. T., aged 62, retired farmer, was sick 4 years and admitted to Mercy Hospital, Dec. 2, 1901.

Personal history and previous illnesses: Usual diseases of childhood. Malaria many years ago. La grippe seven years ago, since that time general health has not been as good as before, though fair. Appetite is good. Bowels somewhat constipated for past four years. No bladder nor kidney symptoms previous to present trouble. Venereal history is negative.

Present trouble: About four years ago patient began to have frequent urination; four times nightly, latterly eight or ten times; small amount of urine passed each time; total amount of urine passed was probably normal. Was treated by irrigation of bladder and local applications of electricity. Took diuretic tablets. About three years ago was unable to urinate and had catheter passed, but has not needed catheterization since until ten weeks ago, when he catheterized himself and has done so several times since that time. For past ten weeks he has irrigated his own bladder daily or oftener with boric acid in boiled water. About eight weeks ago he caught cold and had two quite severe chills followed by temperature of 103 to 104 lasting a day or two, and was confined to bed a week or more. Two days ago patient had slight chill and temperature of 100. Patient complains of no severe pain, but has had some discomfort about perineum and pain running into penis, aggravated by walking, standing and sitting. He has less discomfort when he drinks much water; has burning pain on urination, especially when passing small amounts of concentrated urine; has noticed brick-dust sediment in urine at intervals; has not noticed pus.

December 3: Pulse 84, temperature 98.8; 250 c.c. urine during night. Bladder irrigated with 1 per cent. sulpho-carbolate sodium in 1 to 4000 sol. formalin. Urinalysis: sp. gravity 1016; urine turbid; urea 2.4 per cent. Phosphates increased; indican present; no casts or albumin; many pus cells.

December 10: Bladder has been irrigated daily since admitted. Tonics and diuretics administered, also urotropin. The prostate extends backward, pressing the rectum, and the lobes seem to fill the pelvis to the rami on either side. A stone was detected in bladder with Thompson searcher.

December 11, operation: Technique same as in previous cases. Hooks used. Both lateral lobes, the middle lobe and a portion of the prostatic urethra were removed. The stone was removed with a lithotomy forceps introduced through the neck after completion of the prostatectomy. Rubber drainage tube passed into bladder through perineal opening; this was surrounded with bismuth sub-

iodid gauze as a paeking. Wound closed except on left side, with silkworm gut; left side left open for passage of tube and gauze. Permanent catheter left in bladder through urethra.

Patient returned from operating room and was placed on back rest at angle of 30 degrees. Pulse was 78, low tension; temperature 97.4. He rested quietly and comfortably. Syphon and bottle were attached to drainage tube in perineum.

December 12: He rested very well; pulse 96; temperature 99.4. He drinks considerable water. Dec. 13: Pulse 88, temperature 99. Patient is drowsy and comfortable. Dec. 14: Pulse 82, temperature 99.2; quite comfortable; free drainage.

lent condition. Jan. 1: Catheter with stylet passed. He passes urine by both perineum and urethra. Jan. 5: Wound is healing rapidly. No urine passes through perineum. He is up and walking around room. Patient feels quite well; has control of urine. Jan. 18: All urine passes per urethram; full control. Patient is discharged feeling quite well; can sleep all night without urinating. Urine acid, sp. gravity 1014; trace of albumin; some pus corpuscles.

In a letter received from this patient in October, 1902, patient states that the perineal wound still discharges some urine when he passes his water. He has not complete control over the bladder, as there is some leakage when he coughs or sneezes. He

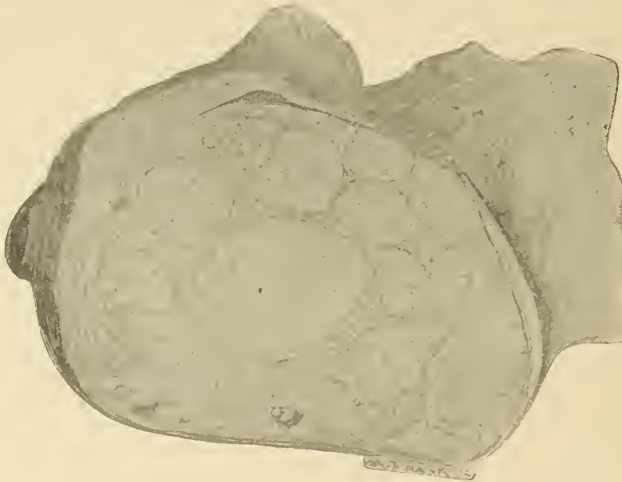


Fig. XIII.

Shows transverse section of right lobe from Case 7, illustrating the numerous small myomata in the upper portion and the hyperplasia in the lower.

December 15: Pulse is 84, temperature 98.4. Patient quite comfortable. Dressings changed three times; some of the paeking removed. He voided 1530 c.c. urine through tube, and slept well. Dec. 16: Pulse 88, temperature 98.8. He voided 900 c.c. urine through tube. Slept ten hours; feels quite comfortable. Dec. 17: Pulse 88, temperature 99; 1200 c.c. urine through tube. Slept ten hours. Dec. 19: Pulse 80, temperature 99; 1500 c.c. urine through tube. Perineal tube and paeking removed. Slept ten hours.

December 22: Pulse and temperature were normal since 19th. Catheter passed through penis. Passes small portion of urine through urethra. Wound in excel-

holds his urine three hours during the day and gets up twice during the night to empty the bladder. Has not had to use the catheter since the operation. Complains of a little pain along the urethra near the wound, when he urinates. Urine contains some pus.

Sexual function markedly impaired. Patient says he is able to attend to his business regularly and that his general health is good.

In a later report received from this patient, April 1, 1903, he states that there is still a sinus in the perineal wound, which communicates with the urethra and discharges a small amount of pus and urine when he urinates, or coughs violently. Control of urine is excellent, except when he

coughs or strains hard. At such times, there is some leakage. Holds urine two and a half to three hours during the day, and about four hours during the night. Has not had to use catheter since the operation. Patient suffers constantly from slight pain and discomfort in the perineal wound, and the irritation of the urine produces pruritis about the wound. No pain in the bladder or urethra. Urine is clear. The sexual function is completely abolished. General health is very good, and the perineal sinus causes him the only discomfort from which he complains. The latter part of March, patient had an acute orchitis which lasted ten days.

CASE 6.—Mr. L. D. R., aged 70, widower. Father died at 88 of strangulated hernia. Mother died at 66 of cancer (?). Two brothers died of prostatic disease, with complications, aged 77 and 82. One brother died of pneumonia at 77. Four brothers living and in good health, aged 60, 64, 73 and 77. Three sisters died of female diseases, ages 50, 52 and 53. He has three sisters living and in good health, ages 60, 68 and 75. He came under observation of Dr. F. A. Turner, Sandwich, Ill., September, 1901, with symptoms of prostatic inflammation, which continued for several days until there was a *free discharge of pus from rectum*, when the symptoms subsided. He did not see him again until Nov. 11, 1901, when present attack began with severe pains in the prostate and a constant desire to pass water, being able to void but small quantities of turbid urine which contained considerable pus. On November 14 complete retention came on, and, notwithstanding the fact that a large amount of pus was discharged from rectum on night of 14th, the retention continued complete until the 22d, the date of the operation. He was catheterized every three or four hours. Amount of residual urine not obtained.

Operation was made November 22. Technique was same as in previous operations. Abscess was found in left lobe. Both lateral lobes were very much enlarged. Lateral and middle lobes were removed.

Post-operative history (kindly furnished me by Dr. Turner): During first six days after operation pulse varied between 114 and

99; temperature between 99 and 97.6; 1/30 gr. strychnia was given hypodermically every four hours. Liquid diet given every two or three hours. Bowels tympanitic and greatly distended during this period, for which he was given tinct. menth. pip. and asafetida, each 1 oz., in 3 pints of water through colon tube, with good results; this was repeated as required.

Bladder was irrigated daily through the drainage tube and the iodoform packing was removed on the sixth day. From the sixth to fourteenth day pulse and temperature were normal. Pus discharged freely from the tube, which was removed on the fourteenth day. Daily irrigation was continued and a fresh piece of iodoform gauze was inserted after each washing. Eight hours after the tube was removed (fourteenth day) he urinated per urethram. Strychnia was given per mouth up to the 20th, when it was stopped.

On December 20th urine passes through urethra and the bottom of the wound is apparently healed. The external portion of the wound is still kept open with a small piece of iodoform gauze. Urine is still turbid; contains pus and is ammoniacal; sp. gravity 1010. During the first week following operation there was a double epididymitis, which was relieved by elevating the scrotum and applying hot fomentations. Dec. 24: Patient is sitting up now and taking solid food. Jan. 5, 1902: Since last letter there has been a free discharge of pus from perineum.

January 16: "The wound in perineum has completely closed. He has control of his urine, which is clear and free from pus. He is not disturbed at night, and has fully recovered. I discharged him Jan. 14, cured."—Turner.

In a report received from this patient March 26, 1903, patient states that a sinus exists at the site of the perineal incision. This sinus evidently communicates with the urethra, as there is a discharge of urine mixed with some pus when bladder is emptied. Holds urine two to three hours during the day, and four hours at night. Has not had to use catheter since operation. No pain in wound except when skin becomes



irritated from urine. Occasionally he has some pain in bladder and urethra. Urine contains a little pus. Sexual function abolished. Patient is able to be around and attends to business. His weight is normal. This case was one of suppurative prostatitis and the abscess was present at the time of operation.

CASE 7.—Mr. C. G., aged 52, laborer, single, was admitted to Cook County Hospital Dec. 7, 1901.

Previous history: States he was perfectly well up to four days ago.

Present illness: Four days ago began having a dull pain in abdomen, which gradually increased until he was compelled to quit

On closer questioning admits gonorrhoea several times and says he has had a stricture. Statements seem unreliable. Denies syphilitic infection. Denies all previous illness. He was a hard drinker for thirty years; smokes to excess now. Friends of the patient say that he has been having "flighty" spells. Patient, himself, says he is "silly" at times, and has been since his parents died, thirty-five or forty years ago.

Examination shows: man past middle age; poorly nourished; in no apparent pain; indifferent to surroundings; mentality poor, so that little dependence can be placed upon his statements. Pupils equal, but contract slowly to light. Teeth covered with sordes;

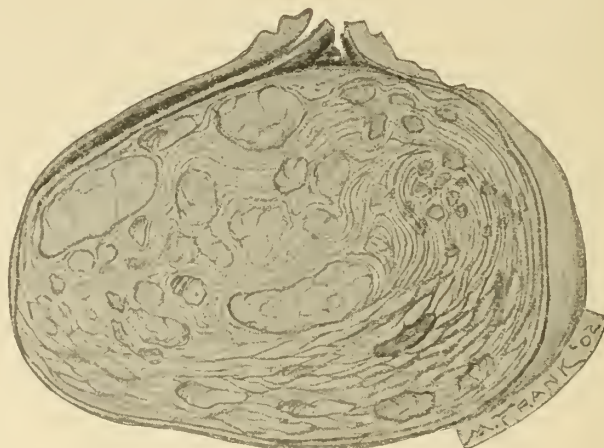


Fig. XIV.

Drawing from cut surface of middle lobe of prostate from Case 7, showing about the same histologic structure as the lateral lobe with distinct loosely attached capsule.

work and go to bed early in the evening; could not sleep that night; next morning vomited three or four times. He has had no appetite since then and "has not been able to keep anything on his stomach." About the time he began vomiting he commenced having trouble in urinating; would have desire to urinate, but could evacuate only a very small quantity, after severe straining. This desire to urinate would come on about a dozen times a day, always with the same result. Says he never had urinary trouble of any kind. Denies all strictures, gonorrhoea, etc. Bowels have not moved for four days. There is no pain in the penis; no cough; no headache or epistaxis.

breath foul. Chest, heart and lungs negative. Tumor mass extending from pelvis above umbilicus, half way to ensiform cartilage; appearance that of seven month's pregnancy; uniform dullness over this mass; no fluctuation obtainable; no fluctuation; auscultation negative; tumor disappeared after catheterization. No stricture; slight urethral discharge in which are gonococci. A very much enlarged prostate, sensitive to pressure but not fluctuating. Has all the external manifestations of an intense cryptogenic infection. Patellar reflex is increased; ulnar reflex diminished.

December 7: Catheterized at 11 A. M. 64 ounces of urine obtained. 5:00 P. M. 68 ounces. 11:30 P. M. 52 ounces.

December 8, catheterized at noon; 45 ounces of urine obtained. Temperature 98.4, pulse 68. December 9, catheterized, 32 ounces urine obtained. Permanent catheter put in. Urinalysis: sp. g. 1018, reaction acid, no albumen or sugar; leucocytes numerous; granular and hyaline casts of large size. December 10: 38 ounces of urine removed; permanent catheter removed. December 12: gonococci found on smear of urethral dressings. Nothing of consequence to note up to date of operation. Patient was repeatedly catheterized and kept on general diet, with saline cathartics. Temperature and pulse ranged near normal, but presented all the time some typhoid conditions, apparently from some hidden sepsis.

Operation of perineal prostatectomy was performed by usual method December 20, 1902. Rubber tube put into bladder, packed around with gauze, and the skin tightly sutured with silk worm gut sutures. (Specimen shown in Fig. XIV.)

December 20: Patient returned from the operation with pulse irregular and weak; respirations shallow and sighing; skin warm and dry; cyanosed, temperature 101, pulse 98. Strychnine sulphate, gr. 1/30 twice daily. Figs. XVI, XVII, XVIII and XIX.

Dec. 21: Patient rested fairly well during the night; liquid diet; pulse 98, temperature 99. Pot. Acet. grs. 10, urotropin grs. 5, twice daily. Dec. 22: Patient slept most of the night; temperature 100.4, temperature 104. Dec. 23: Patient resting well; temperature 99.4, pulse 96. Dec. 24: Patient slept fairly well during night; pulse 96, temperature 99.4. Dec. 25: Pulse 96, temperature 99. Dec. 26: Pulse 100, temperature 101. Dec. 27: Patient slept only at intervals during night. Dec. 28: Temperature 101, temperature 102. Perineal drain removed. Dec. 29: Slept but little during night and refused medicine. Temperature 100.4, pulse 100. Dec. 30: Did not sleep during the night. Temperature 100.4, pulse 100. Dec. 31: Slept fairly well during the night. Temperature 99, pulse 98. Strychnine sulphate gr. 1/30, pot. acet. gr. 10, urotropin grs. 5, twice daily, with light diet. Catheter passed through urethra; bladder empty. Jan. 1,

1902: Patient slept fairly well during the night; temperature 99.4, pulse 108. Jan. 2: Patient rested fairly well during the night. Podophylin et calomel, a.a. grs. 1/2. Temperature 99, pulse 98. Light diet. Jan. 3: Temperature 98.8, pulse 88. Jan. 4: Slept at intervals, only. Temperature 98, pulse 96. Jan. 6: Permanent catheter. Jan. 10: Perineal catheter removed, wound almost healed and urine passed through urethra; general condition about the same as before the operation. All vesical symptoms disappeared.

The mental condition of this patient remained about the same after operation as it was before. The perineal wound entirely healed and he was able to retain urine for several hours. About six weeks after the operation he developed an acute lobar pneumonia and died before he left the hospital.

CASE 8.—Mr. H. H., aged 66, wood-worker, was admitted to Mercy Hospital Dec. 16, 1901. Family history is negative. Personal history: Patient has always enjoyed good health until present illness, with the exception of a month's illness with bowel trouble twenty years ago. Patient's work has not been especially heavy, but it has been often in unheated rooms. Drinks wine and beer occasionally. Venereal infection denied. Constipation since onset of present trouble.

Present illness: Ten or fifteen years ago patient began to have frequent urination, passing only small amount each time. Some discomfort and a feeling that the bladder was not empty often followed urination. This condition was intermittent; was less common in summer than in winter, and was aggravated by exposure and by constipation. This continued, gradually becoming more annoying last summer. It was characterized by more discomfort than ever, and increased frequency of urination. Three weeks ago patient passed some blood, clotted and fresh, with his urine; was unable to pass water for a week thereafter, and catheterized himself from that time until now. The blood has disappeared, and he can not empty his bladder without catheter, there being about five ounces of residual urine. He urinates every two or three hours during the day and rises many times during the night.

December 17: Urinary examination shows sp. gravity 1017; urea 1.5 per cent.; few flat and round cells, considerable mucus; pulse 72, temperature 98.4. Dec. 19: Urine in 24 hours 1500 c.c., reaction acid, sp. gravity 1020; turbid, urea 1.3 per cent.; faint trace of albumin; few squamous cells and pus in quantity. Prostate very much enlarged, particularly on left side.

Operation on January 8, by ordinary method. Rubber drainage tube left in bladder through perineum. Permanent catheter passed into bladder through urethra. Strips of bismuth subiodid gauze packed around perineal rubber drainage tube. One hemostatic was allowed to remain for 36 hours. Wound closed except on left side by silkworm gut. Left side left open for passage of drainage and gauze. There was a moderate amount of hemorrhage. Patient returned from operating room warm and in fine condition. Back rest was placed under patient at angle of 30 degrees. Pulse 78, temperature 97; slight nausea, free perspiration.

January 9: Considerable discharge of urine, some blood. Pulse 88, temperature 99.2. Tubes arranged from catheter and drainage tube to bottle. A portion of the packing was removed. Jan. 11: Pulse 80, temperature 98.4; tube and most of packing removed. Patient is resting comfortably.

January 14: Pulse is 80, temperature 99. Pulse and temperature have remained near normal since 11th. Perineal drainage tube and remainder of packing removed. Wound looks healthy. Urine passed voluntarily, principally by perineum. Patient comfortable, sitting up in bed most of the time.

January 16: Pulse 78, temperature 98.6. Urine passes through perineum. Patient rests well and feels comfortable. Jan. 21: Pulse and temperature normal; 270 c.c. urine in bottle. Wound clean and healthy. Jan. 23: Pulse and temperature normal. Catheter removed; some urine followed through urethra; most of it passes through perineal wound. Patient sleeps well and feels comfortable. Jan. 28: Patient gaining control of urine; most of urine passes through perineum, but quantity through urethra increasing. Jan. 31: Patient can hold urine

several minutes after desire to void is felt. Most of urine passes through urethra; small amount through perineal wound. Patient walking about and very comfortable.

February 4: Patient has walked to dressing room. Wound is closing; very little urine passing through it. Control of urine increases daily. Feb. 7: For past three days urine has been very well controlled; almost the entire amount passed through urethra. Occasionally a small amount is forced through perineal wound. Patient feels fine. Feb. 8: A few leucocytes are in urine; acid in reaction. He passes all urine through urethra and has good control.

In a report received from this patient February, 1903, he states that the perineal wound had remained entirely closed since the operation and that he has complete control of the bladder. He holds urine four to six hours during day and is obliged to get up only once during the night to urinate. Has not had to use the catheter and suffers no pain in bladder, urethra or wound. Urine contains no pus or blood. Sexual function is almost entirely abolished. General health is excellent and he is able to attend to business and enjoys life.

CASE 9.—Mr. C. D. Age 67 years; admitted to Cook County Hospital, January 28, 1902.

Personal history: Infectious diseases of childhood. No history of gonorrhoea. Had sore on penis fifteen years ago and this was followed by sore mouth and sore throat.

Present illness: About five years ago first experienced some difficulty in passing urine. Frequency of urination was increased and he had some pain in bladder during the act, with straining and a sense of pressure at its close. Pain persisted for about one week and then disappeared, but the straining and frequent desire to urinate have persisted to the present time. Urinates about once every three hours during day and night, unless he uses the catheter and completely empties the bladder. After using catheter can often hold urine ten hours. He commenced using the catheter last September and since then has continued its use daily. Right testicle has been swollen for past few days.



Examination: Small stature; poorly nourished. Chest and abdomen negative. Prostate only very slightly enlarged, by rectal examination. Urinalysis; acid, turbid, trace of albumen, no sugar. Pus cells numerous. Residual urine in bladder 4 ounces.

From date of admission to Feb. 7th patient was given urotropin grs. x t.i.d.

Operation: Feb. 7, 1902: Perineal prostatectomy performed. After removal of the prostate it was observed that a fold of muc-

was given urotropin grs. v and sodium phosphate grs. 20, every four hours. Bowels did not move until the 13th, though he was given calomel daily in doses of gr. 1/4 hourly for four hours. Perineal packing was removed Feb. 9th, the perineal drainage tube, Feb. 15th and the permanent catheter two days later. Temperature from Feb. 15th to March 3d remained normal. From March 3d to 13th it was irregular, ranging in the afternoon from 98.6° to 100° F., and on one occasion the 10th, after a slight chill, it rose



Fig. XV.

Case 7 (b).—Left lobe shows enormous hypertrophy of prostatic tissue around a small myoma.

ous membrane protruded from the base of the bladder just posterior to the internal orifice of the urethra, forming a sort of valve to the urethral opening. This fold was cauterized in the median line with Paquelin cautery. Permanent catheter inserted through urethra into bladder and perineal drainage tube introduced below. From Feb. 7th to Feb. 15th, A. M. temperature ranged from 98.6° to 101° and P. M. temperature from 100° to 103° F., with pulse 92 to 112. After nausea from anesthetic subsided he

to 101.8° for a few hours. These temperatures were probably due to some absorption from the urethral tract, as there was nothing else to account for them. After the 13th and until the date of his discharge, April 9th, temperature remained normal. Perineal wound gradually closed and control returned until on March 18th control of the bladder was complete. At the date of his discharge from the hospital he was able to hold his urine three to four hours. For about two weeks after the operation, patient suffered

from partial fecal incontinence when bowels were loose. Complete control however was rapidly regained. This patient has been lost sight of since he left the hospital, so it is impossible to report the ultimate result.

**CASE 10.** Mr. G. Age 69 years. Married. Admitted to Mercy Hospital February 13th, 1902.

Family history: negative. Personal history: negative.

Present illness began eighteen months ago with difficulty in starting urine, passage of a small stream through the urethra and shortly afterwards complete inability to pass any urine, so that he had to be catheterized. This lasted for six weeks, not constantly but at intervals. Occasionally patient passed a little blood in the urine. Has used a catheter continuously since last August.

Examination of patient: Medium stature; poorly nourished. Rectal examination shows lateral lobes of prostate only slightly enlarged. Passage of sound through urethra shows that the prostatic urethra is pushed far forward, evidently by a large middle lobe, necessitating the use of a very sharply curved sound to enter the bladder. No stone found.

Because of the evident enlargement of the middle lobe, and slight hypertrophy of the lateral lobes, it was decided to do a suprapubic cystotomy and remove a portion of the middle lobe through this opening.

Urinary examination: Acid, 1011, cloudy, trace of albumen, no sugar, no casts, many pus cells, few red blood cells.

Operation, February 15th, 1902: Suprapubic cystotomy by median incision through skin down to fascia, extending from symphysis upward for an inch and a half. Attachment of rectus muscle to os pubis divided on each side for half an inch, close to the pubic bone. Bladder now drawn up with forceps and opened. Anchor sutures introduced on each side and interior of bladder explored. Large middle lobe found protruding into the bladder, pushing the urethra forward and obstructing its internal orifice. Paquelin cautery now used to cauterize this middle lobe deeply, the lines of cauterization extending through the neck of the bladder into the prostatic urethra. Several sutures were in-

serted through fascia of rectus and bladder wall, to hold the bladder up and close the pre-vesical space. Rubber drain inserted into bladder, and permanent catheter put in through urethra.

Temperature on afternoon of day of operation 103.8°, pulse 112. From February 15th to February 18th, P. M., temperature ranged from 99.8° to 103.8°, gradually declining each day. It reached normal February 23d and remained so during the remainder of his stay at the hospital. All of the urine drained through the suprapubic tube until February 20th, when the tube was removed. After this, the wound closed slowly. Patient sat up for first time February 23d. On February 27th, he passed some urine through the urethra, for the first time, and on February 28th, almost all of it was coming this way. March 17th, urine was still discharging through a small suprapubic sinus so a catheter was introduced through urethra and retained for several days. Catheter again introduced March 29th and retained for ten days. After this date suprapubic sinus would heal and break open at intervals until April 26th, when it closed permanently. He was discharged from hospital with symptoms relieved and suprapubic wound closed, April 30th, 1902. It has been impossible to trace this patient since he left the hospital, so ultimate result cannot be given at this time.

**CASE 11.**—Mr. E. G. Age 65 years; farmer. Admitted to Mercy Hospital Feb. 26, 1902.

Family history: negative. Personal history: Patient was never married. Denies venereal history. Moderate user of alcohol.

Present illness: About ten years ago patient first experienced some difficulty in passing his urine. There was no obstruction to the urethra, but the difficulty was in starting the stream. This trouble continued about the same until two years ago, when he "caught a severe cold," which caused increased frequency of urination with pain and straining when the urine was passed. At this time he began using catheter and has continued its use daily ever since. During the day he could usually empty the bladder without the cath-

ter, but the stream became very small and he had to urinate very frequently. Considerable pain at end of act. During the night he would have to pass catheter every two hours. About fourteen months ago a suprapubic cystotomy was performed, but patient does not know what the operation was for. Tubes were kept in the bladder for several weeks, and it took a number of months for the incision to heal. He received no benefit from the operation. Use of catheter has been continued, and of late he has had to urinate every hour.

Examination of patient showed suprapubic wound entirely healed. Prostate was much enlarged bilaterally, and quite firm in consistency. Thompson's searcher introduced into bladder showed that no stone was present. There was no real obstruction to the urethra except that offered by the enlarged prostate.

Urinary examination: Reaction alkaline, sp. gr. 1016. Albumen present; many pus cells; no casts.

Operation March 1, 1902: Perineal prostatectomy performed. Permanent catheter used, also perineal drainage tube. Temperature on afternoon of day of operation, 100° F., pulse, 78. March 2d, complained of a good deal of pain in wound. P. M., temperature 100.2°. March 5th. Perineal tube and gauze packing removed. Permanent catheter retained. Temperature from March 2d to 7th: mornings, normal and from 99° to 100° F. in the afternoons. From the 8th to the 15th of March temperature remained normal all day. Sat up in chair for first time March 13th. March 15th evening temperature registered 102.2° without any special cause which could be found. Catheter removed March 17th. Between March 15th and 18th the P. M. temperature gradually declined and remained practically normal until the 26th, when it again went up to 102.8°, without the development of any complication to account for it. From March 26th to April 10th morning temperature was normal, but almost every afternoon it went up to 101° or 102° F. During this time the perineal wound was closing rapidly and there was no inflammatory condition around it. Bowels

were kept moving several times every day with a morning dose of magnesium sulphate when necessary. A diarrhoea developed on March 19th and it was necessary to give the patient large and frequent doses of bismuth subnitrate to check it. On March 28th the perineal wound had entirely closed and there was no urinary leakage from it. He was now put on urotropin in doses of five grs. t.i.d., and bladder was irrigated daily with 1:4000 formaline. Perineal wound leaked a small amount of urine April 4th; April 5th a permanent catheter was put in for twenty-four hours, and then removed because of the urethritis produced. At this time patient could hold the urine from an hour to an hour and a half and had but little pain when he passed it. Discharged from hospital April 17th.

In a report received from this patient March, 1903, he says that the perineal wound has remained entirely healed since he left the hospital. He has complete control of the bladder and holds the urine from one and a half to two hours during the day and about the same length of time during the night. Of late he has occasionally used the catheter at night. Complaints of some pain in the wound and along the urethra. Urine contains some pus, but less than before the operation. Sexual function is completely abolished. Patient, while better than before the operation, still complains a great deal of frequent desire to urinate, straining and inability to completely empty the bladder. No obstruction to the urethra at present, and a large sound falls into the bladder without force. Bladder sounded for stone but none found.

CASE 12.—Mr. X. Age 78 years. Was seen by me in consultation with Dr. Charles D. Lockwood, in Pasadena, Cal., March, 1902.

Patient had suffered with the usual retention of prostatic disease for the past four years, most of the time resorting to the catheter for relief. He had several ounces of residual urine. Urine contained some pus but no blood.

Examination revealed a prostate filling the transverse diameter of the pelvic arch. Operation advised and consented to.

Doctor Lockwood operated and I assisted. The enucleation was rapidly and easily ef-



fected in the usual way. Perineal drain and iodoform gauze packing.

The day following the operation the patient sat up in bed and said he had no special discomfort. There was primary union of the wound down to the drainage opening. In 23 days he was up and around town, with complete closure of the wound and full urinary control.

March 20, 1903, I saw this patient again with Dr. Lockwood. He was looking splendid and said he "did not know he had a bladder." He does not have to get up at night to urinate and goes as long as six hours in the day-time without urinating.

CASE 13.—Dr. F., age 60 years; physician. Admitted to Mercy Hospital, May 10, 1902.

Family history: negative. Personal history: Smokes moderately, has never used alcoholics to excess. Subject to bronchitis (for past twenty years).

Present illness: Three and a half years ago patient was suddenly unable to pass urine, and this persisted for two and a half weeks. During this time he had to be catheterized every day. For the next two years he was free from all trouble, except a slight dribbling at the end of urination and increased frequency of urination. He passed his urine ten to twelve times during the day and once at night. This increased frequency of urination became more marked until about one and a half years ago when he was obliged to pass urine fifteen to twenty times during the day and two to three times during night. He was unable to completely empty the bladder. For the past year he has used catheter once or twice a day and has not had complete control over urination.

Examination of patient: Prostate considerably enlarged, the right lobe being much larger than the left.

Urinary examination: Quantity in 24 hours 2410 c.c. Acid, Sp. gr. 1010; trace of albumen. Microscopic examination: Many pus cells, no casts.

For three days before operation, patient was given urotropin gr. x, three times daily and bladder was catheterized regularly.

Operation, May 14, 1902. Perineal prostatectomy performed. Bladder drained

through perineum by rubber tube and permanent catheter inserted through urethra. Cavity left by removal of prostate packed with subiodide of bismuth gauze. After operation; afternoon temperature ranged between 99° and 100.3° until May 23d, after which date it remained normal permanently. On May 15th patient developed an epididymitis and orchitis on left side, which persisted until May 21st and caused him considerable discomfort and slight elevation of temperature. The orchitis subsided without suppuration. The perineal packing was removed from wound, May 18th. Catheter removed May 24th, three days following removal of perineal tube.

Patient sat up in chair first time May 28th and every day after that he was up and around. Urine commenced passing through the urethra June 12th, the control gradually returning. Perineal wound entirely closed June 17th, but reopened again and discharged slight amount of urine on the 27th. After the 29th it remained closed permanently. Patient discharged from hospital July 4, 1902.

In a letter received from this patient, Sept. 23, 1902, he states that the wound below has remained healed and that he has no pain in the wound, bladder or urethra. Control of the bladder is good and there is no involuntary leakage except a few drops when he coughs or sneezes. He holds the urine three hours during the day and six hours at night. He has not been obliged to use the catheter since the operation. General health is as good as it ever was in his life and he attends to his business every day. The sexual function is completely abolished.

In a later report received, April 1, 1903, patient says: The perineal wound has remained permanently closed, and that he has complete control of the urine. He holds urine five hours during the day and nine hours at night. He has not had to use the catheter, has had no pain in the wound, bladder or urethra. No pus or blood in urine. Sexual function is abolished. General health is excellent, appetite good, patient "enjoys life thoroughly."

CASE 14.—Mr. C. B. B. Age 66, occupation farmer. Admitted to Mercy Hospital, May 9, 1902.

Family history: Negative. Personal history: Moderate drinker; had pneumonia 15 years ago.

Present illness: Began seven years ago with increased frequency of urination, seven or eight times during the night and about once an hour during the day. Bladder always felt as though it was not emptied at the end of urination. About four years after onset a doctor passed a catheter into bladder in order to evacuate it, as patient was unable to do so spontaneously. Except for this one time, bladder was not catheterized until just before he was brought to the hospital, when it again became necessary because of the patient's inability to pass the urine. Frequency of urination continued up to the time of this last attack, and he had considerable pain and straining at end of urination.

Examination: On admission to hospital patient presented a globular swelling in the abdomen extending upward to two inches above the symphysis. Rectal examination showed prostate considerably enlarged, the lateral lobes extending to the ramus of the ischium on each side. With the finger in the rectum as a guide, a stiff catheter was passed into the bladder and part of the urine withdrawn.

Urinary examination: Albumen +. No sugar. Few granular casts, many pus cells. For four days before operation bladder was catheterized every five hours, and ten grains of urotropin given t.i.d.

Operation, May 14, 1902. Perineal prostatectomy performed after the usual method. Permanent rubber catheter introduced and bladder drained through perineal tube.

Temperature on evening of day of operation; 99.2°. Four days later evening temperature was 100.4°, but except for this one day it remained normal during the remainder of his stay in the hospital. May 18th, perineal packing removed.

May 23d, permanent catheter removed. Perineal tube removed May 25th. On May 27th, patient had two voluntary urinations through urethra.

May 29th, sat up in chair for first time. Perineal wound gradually closed, but there was still slight leakage at the time of his discharge from hospital, June 19, 1902.

In a letter received from this patient, October 31, 1902, he states that the wound below has entirely healed. He holds the urine for two to three hours during the day and does not get up at all at night. Has not used catheter since operation and has had no pain in the wound or bladder. No pus or blood in the urine. He states that the sexual function is not materially impaired. He says that his health is better than it has been for ten years and he has gained twenty pounds since he left the hospital.

CASE 15.—Mr. E. S. Age 69 years, married. Occupation farmer. Admitted to Mercy Hospital, May 6, 1902.

Family history: Negative. Personal history: Negative.

Present illness: Began four years ago with sudden, agonizing pain, beginning in left lumbar region and radiating down along the spine. Pain persisted until patient received a hypodermic of morphine. A few months later he had another similar attack. After this was over, he passed several small calculi. He remained well for about two years following this attack except for occasional backaches. Sometimes after riding in a wagon he would pass blood in his urine. For the past year he has suffered from frequent urinations, three to ten times during the night and oftener during the day. Has had some pain along the urethra at the end of urination. A year ago he was unable to pass his urine, and had to be catheterized once. During the past six weeks, the stream has stopped suddenly several times.

Examination: With the Thompson searcher a calculus was found. Rectal examination shows the lateral lobes of the prostate to be very slightly, if any, enlarged.

Urinary examination: Sp. g. 1012, yellow, clear, no albumen, no sugar, no casts or pus.

Operation: May 28, 1902: Suprapubic cystotomy performed. Median incision above symphysis down to fascia, with transverse division of the tendon of the rectus on each side for about half an inch from the median

line. Bladder wall grasped with forceps and drawn up into wound. Bladder wall incised; anchor sutures inserted in each edge of incision, and interior of bladder examined with finger. Two stones found and removed. The middle lobe of the prostate was found to be considerably enlarged, projecting into the cavity of the bladder, pushing up the internal orifice of the urethra. A median incision was made through the bladder mucosa down to the substance of the middle lobe. The latter was then enucleated with the fingers and the mucous membrane sutured over the defect. The anterior bladder wall was now closed with chromicized cat gut sutures about the large rubber drainage tube which was inserted. Gauze drain placed in wound and upper part of skin incision closed with S. W. G. sutures. Permanent catheter not used. Temperature remained normal for thirty-six hours after operation. From May 29th to June 2d, afternoon temperature registered from 99° to 101°. From June 2d to June 11th, it remained practically normal. Bladder was catheterized every four hours. June 1st, rubber drainage tube removed and edges of wound brought together with adhesive straps. Patient sat up for first time June 4th, and left the hospital June 11th, with urine still coming through the suprapubic opening.

CASE 16.—Mr. M. W. T. Age 68 years. Admitted to Mercy Hospital July 7, 1902.

Family history: negative. Personal history: Occupation was blacksmith up to fifteen years ago. Has not used alcoholics to excess. Had diseases of childhood. Parotitis and orchitis (right) at age of 29 years.

Present illness: Onset about twenty years ago. First complained of inability to pass urine and pain of a dull, aching type over the pubes when he attempted to urinate. Also had some sharp pain along the urethra when bladder was full. Six years ago was treated for "bladder trouble" and was catheterized. Since then has had a purulent discharge from urethra and some pus in urine. Has catheterized himself steadily for past six years. Condition has been worse during the last three months.

Examination: Rectal examination showed the prostate gland only moderately enlarged

and soft. The enlargement was not so great as in many other cases of prostatic hypertrophy and pointed toward the probability of an enlarged middle lobe obstructing the urethra. Urine acid, turbid, albumen trace, no sugar, many pus cells.

Operation, July 9, 1902. Typical perineal prostatectomy performed. The lateral lobes were small and soft, the middle lobe projecting into the bladder and elevating prostatic urethra. Permanent catheter introduced through the urethra and the bladder drained through the perineum by means of a large rubber tube.

Temperature on afternoon of day of operation 99.2° pulse 90°. During the next three days temperature in the afternoon ranged from 99° to 100.4°. After July 13th temperature remained normal until patient left the hospital. This patient was not given any urinary antiseptics, as the urine contained only a small amount of pus and was not decomposed.

July 13th, permanent catheter and gauze packing removed from perineal wound. Tube left in bladder. Patient sat up in chair for first time.

July 15th: Perineal tube removed. After this patient began to hold urine in bladder, the sphincteric control rapidly developing as shown by the gushes of urine from perineal wound occurring at progressively lengthening intervals. The perineal wound was rather slow in closing and at the time of his discharge from the hospital, August 6, 1902, urine still came through the incision occasionally, especially after patient had been on his feet for a long time.

In a report from this patient received Oct. 20, 1902, he states that the perineal wound has entirely healed. He holds his urine during the day from an hour to an hour and a quarter; and at night about an hour and three quarters. He complains of some pain in the urethra and at the neck of the bladder when urinating. The urine contains some pus. The sexual function is entirely abolished. He is somewhat under his usual weight, though his appetite is very good. After this report was written the patient passed several small calculi from the bladder, after which



he was very much better and the frequency of urination improved to such an extent that he had to get up only four times during the night. Another letter, written Jan. 8, 1903, states that his improvement has continued and that his health at that time "was very good."

In a later report, March 30, 1903, patient states that the wound has remained permanently closed. He complains of some pain in the testicles and urinates during the day every hour and a half. He thinks that if the testicular pain were absent he could hold urine a much longer time, as it comes on only when bladder is full. Urinates at night every two or three hours and says he has to use some force to start the stream. Has not used catheter since operation. Urine is free from pus or blood. Sexual function permanently abolished. He says that his weight is normal, appetite good and that he is able to attend to his business and enjoys life.

CASE 17.—Mr. A. Age 52 years; occupation, teacher. Admitted to Mercy Hospital July 18, 1902.

Family history: negative. Personal history: No previous illnesses. Had the infectious diseases of childhood. Typhoid fever at 34 years of age.

Present illness: Patient has had enlargement of the prostate for the past eleven years. The principal symptom of which he complains is increased frequency of urination, both day and night. He has to void his urine every one half to two hours during the day and every two hours at night. No pain during urination, but bladder always feels as though it was not quite emptied. No pus or blood in the urine. Never had a catheter passed. General health excellent.

Examination of patient: Medium stature, well nourished, heart, lungs and abdomen negative. Rectal examination shows prostate to be moderately enlarged and very hard. Examination of urine, July 2, 1902. Quantity in 24 hours 1620 c.c. Specific gravity 1015. No albumen, no sugar. Microscopical examination negative, no pus or blood.

Operation July 23, 1902. Perineal prostatotomy performed. Perineal drain inserted into bladder; permanent catheter used.

Temperature on the evening of operation 100.6°, pulse 84. From this time until Aug. 13th, patient a slight evening temperature, ranging from 99.1° to 101.5°. No complications developed at any time to account for this temperature. The gauze packing was removed after 48 hours and the perineal drain at the end of one week. The permanent catheter was removed Aug. 2d. On Aug. 3d the record shows that he passed urine both through the perineal wound and urethra. On Aug. 7th, the entire quantity of urine passed through the urethra for the first time, and after that date there was no leakage through the perineal wound. Discharged from Hospital Aug. 18th, 1902, with wound closed and urinary control good.

In a letter received from this patient Oct. 24, 1902, he states that he is in perfect health, that the wound below has remained entirely closed and that he has complete control of the urine. Urine is held during the day two and a half hours and during the night three and a half hours. He has no pain but complains of slight irritation in the urethra in the morning. The urine is negative, containing no blood or pus. Patient has had no erections since the operation. His weight has increased, his appetite is good, and he is able to attend to all of his duties.

In a report from this patient March 30, 1903, he says that the perineal wound has remained permanently healed and that he has complete control of the urine. Holds urine two and a half to four hours during the day and four or five hours during the night. He has not had to use catheter since the operation. No pain in wound. Some slight pain in urethra occasionally in the morning. Urine clear. Sexual function markedly impaired. General health excellent.

CASE 18.—Mr. W. P. D. Aged 62 years; married. Occupation, traveling man. Admitted to Mercy Hospital, Aug. 12, 1902.

Family history: Negative.

Personal history: Had diseases of childhood. Has always worked hard and has always been a moderate user of alcoholic liquors. No venereal history.

Present illness: Began about one year ago, suddenly, with inability to pass his

urine. Had to be catheterized. Since that time he has suffered from burning pain in the glans penis, a sense of weight in the pelvis and increased frequency of urination. He has to get up frequently at night and often can pass only a few drops of urine at a time. Also complains of dizziness and forgetfulness.

Examination: Medium stature, short and of heavy build. Rectal examination shows prostate to be enlarged, the enlargement affecting both lobes which are moderately firm in consistency.

Operation, Aug. 13, 1902. Perineal prostatectomy performed as in previous cases, except that after removing the lateral lobes of the prostate, sufficient of the urethral mucus membrane was left to suture over the permanent catheter, which was introduced through the penis. Bladder drained through perineal tube. Temperature on the evening of the day of operation 102.2°, pulse 100. After this until August 21st the afternoon temperature ranged from 100° to 101.6°, with no complications to account for it. Perineal drain and packing removed August 17th. Permanent catheter removed August 21st. Patient sat up in chair Aug. 24th, and on the same day he passed some urine through the urethra for the first time. After this date the amount of urine passed through the urethra increased daily, and the control was rapidly re-established. On Sept. 12th, perineal wound was entirely closed and remained so during the rest of his stay in the hospital. Patient was discharged from hospital Sept. 23, 1902.

In a letter received from the patient Nov. 22, 1902, he states that the perineal wound has remained closed and that he has good control of the urine. There is some scalding in the urethra when he passes his urine and some slight leakage through the urethra when he sneezes or coughs hard. He holds urine from two to three hours during the day and from three to four hours at night. Urine is clear and contains no blood or pus. His sexual function is greatly impaired and he has had no erections since the operation.

In a report received from this patient, March 30, 1903, he says that the perineal wound has remained permanently healed and

that he has complete control of the urine. Holds urine from five to seven hours during the day and about six hours during the night. He has not had to use catheter since operation and has no pain in wound, bladder or urethra. Sexual function completely abolished. General health good, except that he has had a series of colds during the winter.

CASE 19.—Mr. E. J. W. Age 60 years. Single. Photographer. Admitted to Cook County Hospital Aug. 24, 1902.

Family history: negative. Personal history: negative.

Present illness: The day before entering County Hospital, patient was troubled with frequent urinations. The night before he came in he had to get up fifteen times to pass his urine. Each time the amount was less, until, finally he could pass only a few drops. Desire to urinate was constantly present, however, and bladder rapidly filled. At time of admission was unable to urinate at all, and had to be catheterized.

Previous history: Had gonorrhea 20 years ago, several times. This was followed by "gleet." Says that he has had no urethral discharge for many years. Last winter was troubled with frequent urinations but had no retention. He had one attack of retention about a year ago, but flow started before it was necessary to use the catheter.

Examination: Bladder enormously distended, reaching almost to the navel. Patient is unable to pass any urine, except when he strains hard, and then only a few drops at a time are expressed. Rectal examination shows prostate to be greatly enlarged, and of a very firm consistence. It is tender to pressure. Both lateral lobes are affected.

Examination of urine: Amber, normal odor, acid reaction, sp.g. 1020, no albumen, no sugar, few red corpuscles.

Operation Aug. 26, 1902: Perineal prostatectomy; bladder drained through perineal tube. Gauze packing in wound; permanent catheter inserted. The two lateral lobes were removed, also small middle lobe. Temperature afternoon of day of operation 98.6°, pulse 100°. Urotropin, grs. v, and spts. aetheris nitros, xx ordered, t.i.d. From the 27th of August to September 6th the after-

noon temperature ranged from 99° to 101°, on one occasion, Sept. 4th, reaching 102° F. This temperature was due to a right-sided epididymitis and orchitis, which developed Aug. 30th and caused the patient considerable pain and discomfort. Gauze packing was removed Aug. 28th and the perineal drain one week later, September 1, 1902. Daily irrigations of bladder with saturated boric acid solution, ordered.

On Sept. 7th, pain in the right testicle became severe and temperature rose to 104° F. The swelling in the epididymitis was very sensitive to pressure and the entire cord was swollen and tender up to the external ring. Ice bag applied to scrotum. Perineal sutures removed. On Sept. 8th, temperature dropped to normal, and remained so during the rest of his stay in the hospital. Permanent catheter removed Sept. 17th, and patient was up and around Sept. 19th. Perineal wound closed rapidly and urinary control was quickly regained after the permanent catheter was removed.

Oct. 7th, wound closed completely. Oct. 8th, wound again discharging small quantities of urine during micturation. A very small sinus remained in the perineal wound until Oct. 17th. Oct. 21st, patient in excellent general condition and feeling well. He urinates a large amount every two hours, on an average, and usually without pain. Occasionally he has slight pain in glans penis during urination. Control is good, though after micturation there is some dribbling for a few minutes. Perineal wound is healed; no urine through it for the last four days. Previous to four days ago, the small sinus would occasionally open up and discharge a few drops.

Rectal examination shows only a slight thickening in the situation formerly occupied by the enlarged prostate. Examination of urine, Nov. 7, 1902; yellow, 1012, acid, trace of albumen, no sugar, moderate number of pus cells.

This patient has not been heard from since he left the hospital, so we cannot report the ultimate result of the operation.

CASE 20.—Mr. J. B. Age 60 years; married. Occupation, watchman. Entered Cook County Hospital, Sept. 29, 1902.

Family history: Negative. Personal history: Moderate user of alcohol. For past seventeen years has been a watchman and exposed to cold and wet. No serious previous illnesses, except inguinal adenitis on left side about thirty years ago.

Present illness: Began about September, 1901, when he commenced to suffer from frequent urinations. This gradually increased in severity and in a short time he was obliged to urinate every hour during the day and five or six times during the night. Often had trouble in starting urine, and was unable to completely empty the bladder. The symptoms were occasionally absent for several days at a time. Just after admission to hospital patient was unable to pass any urine for seventeen hours, and it was necessary to catheterize him. After this he was catheterized twice daily, until operated on. Before admission to surgical ward, patient had been treated in medical ward for chronic myocarditis and nephritis. The symptoms due to these lesions had almost entirely subsided before he was transferred.

Examination: Fairly well nourished. Small amount of fluid present in right chest at base, posteriorly. *Heart*: slight blowing murmur in third left intercostal space, systolic in time; compensation good. Abdomen: bladder distended, forming a rounded tumor above the symphysis. Rectal examination shows the prostate markedly enlarged and of firm consistency.

Urinary examination: Yellow, pale, 1013, albumen +. No sugar. moderate number of hyaline and granular casts, few pus cells.

Operation, Sept. 26, 1902; perineal prostatectomy performed. Both lateral lobes removed, with the middle lobe, which was about the size of a hazel nut. Permanent catheter introduced through urethra, and rubber drainage tube into bladder through perineal wound. Wound packed with bismuth subiodide gauze. From Sept. 26th to Oct. 15th, afternoon temperature ranged from 99° to 100.6°. On one occasion, Oct. 11th, it went up to 102.3°. Patient put on Diuretin, grs. xv, and infusion digitalis



drachm iv, every four hours. Sept. 29th, perineal packing loosened and partly removed. Urotropin, grs. xv, t.i.d., ordered and diuretin stopped. Sept. 30th, remainder of gauze packing removed. Oct. 1st, perineal drainage tube removed. Oct. 2d, daily irrigations of bladder with saturated boric acid solution, ordered. Oct. 4th, sutures removed. Oct. 6th, permanent catheter removed. Oct. 9th, patient developed some moist rales and rough respiratory sounds at right base posteriorly, above level of dullness, and two days later a friction rub was heard in right lower axillary region. On this date, temperature rose to 102.2°. From Oct. 15th to Oct. 21, temperature was normal and patient felt well. Oct. 23d, patient complained of dyspnoea and swelling of legs. Examination showed the presence of fluid in the right chest and also fluid in the abdomen. Lower limbs and scrotum were oedematous. Perineal wound almost healed, except at the left lower angle, where there was a small sinus, which discharged urine when patient micturated. On Oct. 23d, 1200 c.c. of fluid aspirated from right pleural cavity, and dyspnoea considerably relieved. From Oct. 4th until date of discharge from hospital, temperature remained normal except when abscess found in testicle Jan. 1st. Nov. 10th there was still a sinus in the perineum so catheter was introduced into bladder and allowed to remain, for a few days. Nov. 28th, oedema of legs has disappeared. Perineal wound has discharged no urine for several days until this morning, when it re-opened and discharged about a drachm. Some fluid still in right pleural cavity. After this, wound closed and re-opened at intervals. Urinary control all of this time was good, and he was able to hold his urine from two to three hours at a time. On Dec. 10th, patient developed a slight swelling and tenderness of right epididymis. This epididymitis remained latent for nearly four weeks, and during this time caused him very little inconvenience except some slight pain and tenderness. After about four weeks these increased, fluctuation developed and an abscess was evacuated. After this, abscess cavity rapidly contracted and closed. Pa-

tient discharged from hospital with perineal wound closed, Jan. 13, 1903.

In a report received from this patient April 2, 1903, he states that wound has opened periodically since he left the hospital, discharging a little urine for a few days and then closing. No discharge from perineum for past week. His general health is good. He has excellent control of urine and holds it from three to four hours during the day, and from two to three hours at night. No pain at any time. The urine contains a few pus cells, but no albumen or casts. Sexual function is completely abolished, but not as a result of the operation, for it had not been present for a year and a half previous to the operation.

CASE 21.—Mr. F. D. Age 68 years; occupation, farmer. Admitted to Mercy Hospital Sept. 26, 1902.

Family history: negative. Personal history: No serious illnesses. Never used alcohols to excess.

Present illness began fifteen years ago, when as he expressed it he "took cold in his bladder." At that time he had frequent urinations, but with very little pain. The stream would stop suddenly at times and there was slight burning in the bladder quite constantly. He also passed clots of blood. For the last nine years frequent and painful urinations have been complained of all the time. For the last five years he has used the catheter daily, of late seven or eight times during the day and six at night. Passage of catheter causes pain and he also has severe pain when any urine collects in the bladder. He also has considerable rectal pain when bowels move.

Examination: medium stature, fair nourishment, lungs and heart negative; abdomen, liver palpable to level of umbilicus. Rectal examination shows moderate prostatic enlargement, symmetrical; prostate hard and firm. The distended bladder can be palpated bimanually. Right testicle somewhat atrophied. Double inguinal hernia present. A Thompson searcher was passed into the bladder and a large stone found. Examination of urine: yellow color, turbid, fetid odor, alkaline reaction, large amount of albumen.

Microscopic examination showed large numbers of bacteria and pus cells. Temperature P. M. 101.8°. Given urotropin and sodium phosphate for two days before operation.

Operation Sept. 29, 1902. The prostate was removed through the perineum in the manner above described. After the removal of the gland, the finger was inserted into the bladder and the calculi located. Stone forceps were now passed into the bladder and five calculi, varying in size from a hickory nut to a golf ball were removed. The stones were faceted and fitted together. Permanent catheter inserted through penis and one cat-gut suture used to partly unite the mucus membrane of prostatic urethra over catheter. Perineal tube and gauze packing allowed to come out of the left angle of the wound. Temperature in the evening of day of operation 103°, pulse 124. Complained of severe headache and considerable pain in the wound. Bladder irrigated with 1:5000 formaline solution every six hours. Temperature on afternoon of Sept. 30th, 102° and pulse 102. Patient feels much better and suffers only slight pain. Urotropin, grs. v, methylene blue gr. ii and infusion of tritium repens ordered three times a day. From this date until Oct. 4th temperature reached 100° in the evening, and he complained of very little pain. On Oct. 3d the perineal tube and part of the gauze packing was removed. On Oct. 4th the remainder of the packing was removed. Drainage through catheter perfect. From Oct. 4th to 10th temperature was normal. On the 10th and 11th it reached 102° in the afternoon, but there were no other symptoms. After that date it remained normal permanently. Patient sat up in chair Oct. 8th and was up every day after that. Urine was passed through perineal wound for about a week after the permanent catheter was removed on Oct. 8th. On Oct. 16th he began passing the urine through the urethra and from this time on the perineal wound closed rapidly. The bladder irrigations which were used during the first few days after operation were discontinued Oct. 3d. The urotropin, methylene blue and tritium repens were continued while the patient remained in the hospital. Patient was dis-

charged from hospital with perineal wound entirely closed and urinary control good on Oct. 24, 1902.

In a report received from this patient February, 1903, he states that the wound is entirely healed and that he has complete control of the urine. Holds urine three to four hours during the day and six to seven hours during night. Has not used catheter since operation; has had no pain in bladder or urethra and urine is nearly clear. Sexual function is entirely abolished. His health is first class, he has gained thirty-nine pounds in weight. Attends to business and thoroughly enjoys life.

CASE 22.—Mr. P. D. Age 49 years; occupation, laborer. Admitted to Mercy Hospital Nov. 8, 1902.

Family history: negative. Personal history: Has used alcohol for many years, formerly to excess. Denies venereal infection. Present illness: About four years ago first noticed difficulty in urination. The urine was slow in starting, the force of the stream was lessened, and urine inclined to dribble. At first these symptoms were slight, but gradually increased in severity, until at present the urine is voided with great difficulty, and often he is unable to pass any urine for several hours. He has frequent desire to empty bladder and suffers great pain from the tension. During the passage of the urine he has burning pain in the urethra. Voids urine three to five times during the day and from five to seven times during the night. Has never used catheter.

Examination: Shows prostate to be considerably enlarged. No stone found in the bladder. Urinary examination: sp.g. 1030; yellow, no albumen, no sugar, no pus or blood.

Operation, Nov. 10, 1902. Perineal prostatectomy performed; permanent catheter not used. P. M. temperature on day of operation 99.2°, pulse 90. Nov. 11th. A. M. temperature 100°, pulse 88. Patient feeling comfortable and complains of but little pain. P. M. temperature 101.2°, pulse 100. Patient put on urotropin grs. v, t.i.d., and large doses of infusion of tritium repens. From Nov. 12th to 16th, temperature ranged, in the afternoon

from 98.6° to 101.8°. After that date it remained practically normal until he left the hospital. Perineal packing was removed Nov. 12th, and the tube Nov. 17th. On Nov. 20th it was noted that he had good control of the bladder, but passed the urine frequently. Nov. 22d, sat up in chair, for first time, and continued up every day afterwards. Patient discharged from hospital Nov. 10th, with perineal wound practically healed and with good control of urine.

CASE 23.—Mr. J. W. Age 71. Admitted to Mercy Hospital, Jan. 4, 1903.

Family history: Negative. Personal history: Negative.

Present illness: For the past eighteen years patient has suffered from frequent urinations, especially at night, so that he has had to get up three or four times to evacuate the bladder after going to bed. For the past three months the difficulty in passing his urine has increased, and he has suffered from burning along the urethra during micturition. Three months ago he was unable to pass urine and had to be catheterized twice daily for eight days. Symptoms have been more severe since then and pus has been present in the urine.

Examination: Small man, poorly nourished, arteries sclerotic. Prostate considerably enlarged bilaterally.

Examination of urine: 1680 c.c. in 24 hours; 1008, yellow, turbid, albumen present, no casts, large amount of pus.

Operation, Jan. 7, 1903. Perineal prostatectomy performed. Right lobe of prostate showed uniform enlargement and left lobe, an adenoma about the size of a cherry, resembling a uterine fibroid. Both lateral lobes and central mass removed without opening the urethra. Urethra opened in median line and large drainage tube inserted. Permanent catheter not used. Wound packed with bismuth subiodide gauze. Temperature after operation 98.6°, pulse 128. Temperature evening of the 7th, 99.6°, pulse 120. Patient given strychnia gr. 1/60 and infusion digitalis drachms ii every four hours. Jan. 8th, P. M. temperature 99.4°, pulse 100. Jan. 9th, gauze packing removed from perineum. P. M. temperature 100.2°, pulse

114. Jan. 11th, P. M. temperature 99.6°, pulse 108. Patient complains of considerable pain in wound. Free bowel movements secured daily by the administration of magnesium sulphate.

Jan. 11th, as bowels did not move freely; he was given small doses of calomel followed by magnesium sulphate. Sodium and potassium bromide, a.a. grs. x, ordered for restlessness. Some slight mental confusion was noticed after patient was awakened from sleep. Patient extremely restless and complains of pain in the left lower portion of abdomen, which, was tender to pressure. Much flatus expelled. Jan. 12th, P. M. temperature 99.8°, pulse 104. Pain much less severe, and patient has had some sleep. In the evening restlessness returned and he was slightly delirious. Jan. 13th, mind still wandering; complains of pain in the wound. Bowels moving freely, and urine abundant. P. M. temperature 99°, pulse 106.

From Jan. 13th to 17th, temperature remained normal and pulse ranged from 94 to 110. He slept fairly well, and seemed very much better in every way. On Jan. 15th, he had desire to urinate, and a feeling as though urine was coming through urethra. Perineal tube removed. Was out of bed, on couch, Jan. 15th, and sat up in chair Jan. 16th. At this time appetite was good, wound looked healthy and temperature was normal. On Jan. 17th, while sitting up had an attack of vertigo with severe palpitation, temperature suddenly went up to 104° at twelve o'clock noon, and at the same time pulse was 134. Coincident with the rise of temperature patient became very stupid and had muscular twitchings on right side. P. M. temperature 103.8°, (ax), pulse 130. Muscular twitchings persisted and patient became irrational. Jan. 18th, A. M. temperature 101°, pulse 112. Mental condition better, and he slept some during the night. Desire to urinate, accompanied by a great deal of pain. P. M. temperature 101°, pulse 116. Muscular twitchings much less. Toward evening, twitching again became marked. Spts. Frumenti drachms iv given, also, pot. et. sodium bromide, a.a. grs. xxx, with chloral grs. x, per rectum. Jan. 19th, A. M. temperature 101.4°, pulse 126. Rational only



at intervals, bromides, chloral and spirits continued, without apparent effect. Saline enemas given, but not retained. Toward noon patient rested very much better. P. M. temperature 102.4°, pulse 136. Jan. 20th, A. M. temperature 100, pulse 120. Bladder irrigated twice with 1:4000 formaline. Bromides and chloral repeated per rectum. Gr. 1/2 eodine given hypodermically. P. M. temperature 102.6°, pulse 132. Complains of pain in bladder, and is very restless. Jan. 21st, A. M. temperature 105.6°, pulse 132. Had hard chill, for twenty minutes. Bladder irrigated with 1:4000 formaline, no odor from urine wound, looks well. Muscular twitchings in right arm and hand. P. M. temperature 103°, pulse 148. Involuntary discharges from bowels. Medicines by mouth discontinued, and strychnia sulph. and digitaline given hypodermically every four hours. Jan. 22d, A. M. temperature 102.8°, pulse 138. Twitchings continue. Patient delirious. P. M. temperature 104.4°, pulse 150; involuntaries. Entire body in a tremor. Jan. 23d, pulse weaker, patient restless. Twitchings continue. A. M. temperature 102.4°, pulse 168. P. M. temperature 104.6°, pulse 172. Respirations short and labored. Perspiring freely. Jan. 24th, pulse became so rapid after midnight that it could not be counted, and patient died about nine o'clock. Postmortem not made.

CASE 24.—Mr. A. B. Age 63 years. Occupation, farmer. Admitted to Mery Hospital Jan. 10, 1903.

Family history: negative. Personal history: negative.

Present illness: Began three years ago when patient noticed that it took him some time to start urine and that the frequency of urination was increased to every two or three hours. Trouble was always worse in winter than in summer. Eighteen months ago he began to catheterize himself, passing catheter about every three hours. He has kept up this practice until the present time. Urination without the catheter is very painful and he is not able to completely empty the bladder.

Examination: Prostate considerably enlarged, the enlargement affecting both lobes, the left being larger than the right. Urinary-

sis: yellow, acid, trace of albumen, no sugar, pus cells abundant, no casts.

Operation, Jan. 12, 1903. Perineal prostatectomy performed. Both lateral lobes and central lobe removed without opening the urethra. The prostatic urethra formed a small pouch so that it was necessary to remove a portion of it and partially reunite the edges with cat gut. Bladder drained through perineal tube. Wound packed with bismuth sub-iodide gauze. Temperature on the evening of the 12th, 100.4°, pulse 100. From the 12th to the 15th afternoon temperature ranged from 100° to 100.4°; after the 15th it remained normal throughout his stay in the hospital. Packing removed on the 14th and perineal tube removed on the 18th. Urotropin grs. v started Jan. 14th and continued. Patient sat up in chair first time Jan. 25th. Feb. 6th perineal wound nearly closed, only a small portion of urine coming through it when voided. Patient discharged from hospital Feb. 11, 1903, with perineal wound closed and good control of bladder.

In a report received from this patient April 1, 1903, he states that the perineal wound has remained permanently healed, and that he has complete control of the urine. Holds urine about two and a half hours during the day and about the same length of time at night. Has not had to use catheter since the operation. Occasionally some pain in the region of the wound, after he has been on his feet. Urine contains some brown sediment. Sexual function greatly impaired. Has not had any erections since the operation. General health excellent. Weighs 190 pounds.

CASE 25.—Referred by Dr. G. Fleming, Austin, Ill. Mr. S. C. Age 57 years; occupation, weigher. Admitted to Mery Hospital Jan. 11, 1903.

Family history: negative. Personal history: No serious illnesses; never used alcohol to excess. Present illness: Began about five years ago with increased frequency of urination and at times slight pain during the act. The frequency was present both day and night. For a few years he was troubled only during the winter months and was practically free from the symptoms during the summer time. Last summer these two symptoms

painful and frequent urination, were present in slight degree and persisted until about one month ago, when they suddenly became very much aggravated. During the last week severe pain and straining during the passage of urine have given him but little rest. He urinates every 20 to twenty-five minutes, passing but a small quantity of urine each time, and usually only after several ineffectual efforts to start the stream.

Examination of patient: Large stature; well nourished; heart and lungs negative. Rectal examination shows the prostate to be very much enlarged bilaterally and of firm consistency. Metal sound could not be passed into the bladder because of the very severe pain which he suffered when the tip of the sound reached the prostate. Because of the severe pain and straining during the passage of the urine and the presence of blood in the specimens passed, it was thought that a stone might be present. An x-ray photograph of the pelvis was taken, but no stone found. Urinary examination: Acid, 1013, clear, albumen present. Few blood cells and many pus cells found in the centrifuge specimen.

Operation Jan. 12, 1903. Perineal prostatectomy performed. The operation was more difficult in this case than usual, because of the very deep situation of the prostate and the difficulty of getting the fingers above the upper border during the enucleation. The lateral lobes were greatly elongated, being two and a half inches long and two inches wide. The central lobe was about the size of a small almond. In this case the permanent catheter was not used. The cavity left by the removal of the prostate was packed with bismuth subiodide gauze and the bladder drained through the perineum by means of a large rubber tube. condition after the operation excellent; temperature normal, pulse 94. In the afternoon complained of severe pain in the wound. Temperature 100.6°, pulse 94. Jan. 13th temperature 100°, pulse 84 in the evening. After this and until his discharge from the hospital temperature remained normal except on one occasion, Feb. 4th, when without apparent cause it rose to 101.6° for a few hours. Feb. 14th he was given urotropin grs. v. t.i.d., which was continued until his

discharge. Perineal packing removed Jan. 14th, and drainage tube on 19th. Patient sat up in chair first time Jan. 26th. On Feb. 6th patient had control of bladder to the extent that he could hold urine for about one hour. On Feb. 8th a catheter was passed through urethra to prostatic portion, but it could not be passed into the bladder. That night he passed urine through the urethra twice. Feb. 15th perineal wound had almost entirely closed but there was occasionally a very small amount of urine escaped this way during micturation. Patient discharged from hospital Feb. 16, 1903.

In a report received from this patient April 1, 1903, he states that the perineal sinus closed entirely March 16th and has not since leaked. The scar in the perineum is slightly tender to pressure, but he has no pain in bladder or urethra. During the day he holds his urine two to two and a half hours and gets up only three times at night; goes to bed at 10 P. M. and arises at 7 A. M. The stream of urine is full and he experiences no difficulty or delay in starting it. His general health is excellent; weight up to normal; sleeps well and feels strong. Sexual desire has disappeared and he has no erections.

CASE 26.—Mr. E. O. Age 54 years. Occupation, stock-raiser. Admitted to Mercy Hospital, Jan. 19, 1903.

Family history: Negative. Personal history: Negative.

Present illness: Onset three or four years ago, when patient was troubled with frequent desire to urinate. Passage of urine being accompanied by burning in the urethra. These symptoms have continued until the present time. After a good deal of distress in the bladder, he is able to pass a small quantity of urine, but cannot completely empty the bladder. Three or four times during the last year and a half he has been unable to pass any urine and has had to be catheterized daily for a week or two. The straining has been so constant that he has developed a prolapse of the rectum and hemorrhoids, which in themselves cause him considerable pain and distress. Symptoms were always worse in the cold weather.

Examination: Prostate enlarged to moderate degree and of hard consistency.

Urinalysis: Yellow, turbid, trace of albumen, no sugar, numerous pus cells, no casts.

Operation, Jan. 21, 1903. Perineal prostatectomy performed. Lateral lobes of prostate the size of a large walnut each. Median lobe about the size of an almond and projected into the lumen of the urethra. The prostatic urethra was dilated, and after the removal of the lateral lobes the two flaps of urethral mucous membrane were brought together in the median line and sutured with cat gut. Bladder drained through large perineal tube and wound packed with bismuth gauze. On the afternoon of the 21st, temperature was 99° and pulse 108. From Jan. 21st to Jan. 30th, P. M. temperature ranged from 99° to 100.4°, with pulse 80 to 90. Bowels were removed with drachms ii doses of aromatic cascara, daily. Perineal packing removed Jan. 23d and the tube a week later. Jan. 25th, patient was ordered urotropin grs. v. t.i.d. From Jan. 30th to Feb. 1st, P. M. temperature ranged from 100.4° to 102.2°, without apparent cause. Feb. 2d to Feb. 10th, P. M. temperature was irregular, some days remaining normal and others registering 99.4° to 102.6°. After the 10th, temperature remained normal until date of discharge. Patient sat up in bed for first time Feb. 5th and was discharged from hospital Feb. 22d. Perineal wound closed completely Feb. 13th, and after that there was no leakage from it. At the time of his discharge from the hospital the control of bladder was good and he held urine three to four hours.

In a report received from this patient, April 1, 1903, he states that the wound has remained healed, and that he has complete control of the urine. Holds urine one and a half to three hours during the day and from three to four hours during the night. He has not had to use catheter since operation. He has some slight pain in the wound and along the urethra after being on his feet a good deal. Urine is clear. Sexual function abolished. Patient says that he has desire but "cannot accomplish the act." General health good, appetite good, sleeps

well and is gaining in weight. Has some slight soreness in the testicles.

CASE 27.—Mr. F. Age 65 years.

The following history of this case is from memory, as the hospital record was purchased:

Admitted to Mercy Hospital Feb. 13th, 1903. He suffered from evidences of prostatic hypertrophy during the past four years, the symptoms increasing in severity and for the last year being very annoying. Examination showed a very much hypertrophied prostate, the left lobe being larger than the right.

Operation, Feb. 18, 1903: Usual prostatectomy was performed and no difficulties encountered.

The course following the operation was remarkably smooth for 4 weeks. The perineal packing was removed on the second day after the operation, and the tube came out on the third day. Urine escaped from the sinus left by the tube, when he urinated. He was allowed out of bed about ten or twelve days after the operation, and the urine had commenced to come through the urethra at that time, but only in very small quantities. Perineal sinus persisted, but his control of the bladder was excellent and he was able to hold the urine for several hours. He had no temperature at any time after the first few days following the operation, until the 15th of March, when he developed a slight cough, with scattered moist rales over both lungs. He complained of no symptoms referable to the bladder or perineum at this time, and did not feel sick. His temperature on the 15th was about 101° F. After this the cough persisted, but at no time was any consolidation of the lung detected. Afternoon temperature ranged from 101° to 102.5° F., with pulse 90 to 100. He had the classic symptoms of La Grippe, similar to many other cases in the hospital at that time. On March 20th, a to-and-fro rub was heard over the pericardium, and patient complained of some slight pain in this region. This rub was heard best during respiration (a pleuro-pericardial friction.) About 24 hours after the rub was first heard, patient suddenly became paralyzed on the left side. At first the hemiplegia was complete but twelve hours after



onset he was able to move his leg. Consciousness was not lost at the beginning, but he could not talk. Temperature that night registered about 103° F., and pulse about 110. Patient gradually lapsed into unconsciousness. pulse became more rapid and temperature remained high. He died March 22d, in the evening.

In this case there seems to have been no connection between the operation and the illness which caused his death. His convalescence after the operation had been perfect, the wound had healed rapidly, the urine was normal and he had had no fever at any time before the onset of the fatal illness. The lesion was undoubtedly cerebral embolism, secondary to an endocarditis, but the cause of the endocarditis is obscure.

CASE 28.—Mr. E. F. H. Age 47 years. Occupation, plumber; married. Admitted to Mercy Hospital, Feb. 18, 1903.

Family history: Mother died of carcinoma.

Personal history: Typhoid fever and pneumonia at 17 years. Has been subject to frequent attacks of diarrhoea. Formerly used alcoholics to excess.

Present illness: Dates from about fifteen years ago, when he was working in a lead smelter. At that time he developed lead colic, followed by diarrhoea; was sick about two months, and after getting out of bed complained of weakness in his extremities. After this, passed large quantities of mucous from the bowels. Under treatment the colitis improved, but he has had attacks of it since then, after working hard. During the past year patient has suffered from irritability of the bladder, being obliged to urinate frequently during the day and from one to three times during the night. The principal symptom from which he suffers, however, is a constant burning sensation at the base of the bladder. He is never free from this burning, and it is sometimes aggravated by urination. He also complains of frequent nocturnal emissions, accompanied by great burning pain in the perineum. Sexual power has markedly decreased of late. Has lost about ten or fifteen pounds in weight since onset.

Examination of patient: Medium stature; fair nourishment; heart and lungs negative; abdomen negative. Rectal examination; the prostatescope shows the mucous membrane to be normal; palpation reveals presence of slightly enlarged prostate, the left lobe being larger than the right. No stricture found in the urethra and no stone in the bladder.

Examination of urine: Acid, 1030, no albumen, no sugar, very few pus cells.

Operation, March 4, 1903: Perineal prostatectomy performed by my associate J. M. Neff. Left lobe larger than right; both removed, with the posterior prostatic urethra, and a few cat gut sutures used to bring the lateral edges of the prostatic urethra together to form a new floor. Perineal drainage of the bladder; wound packed with subiodide bismuth gauze. Temperature afternoon of operation 99°, pulse 88. From March 5th to 14th, afternoon temperature ranged from 99° to 101°. During this time he complained of a considerable pain in the perineal wound during the first few days. Perineal packing partly removed March 7th, but hemorrhage was so profuse that it was necessary to re-pack. Perineal packing removed March 8th, without recurrence of hemorrhage. On March 15th, patient suddenly developed temperature of 104°, pulse 110. He complained of considerable cough and moist rales were present over both lungs. Cotton jacket put on, and ammonium carbonate and chloride, in five grain doses, administered. Temperature remained up until the afternoon of March 17th, when it came down to normal and remained so during the rest of his stay in the hospital. Ten days after operation, patient began to get control, as was shown by the urine escaping in gushes and not continuously. After this the perineal wound granulated quite rapidly; the urine began coming through the urethra, at first in drops and later in larger quantities, so that when he left the hospital, all of it was coming in this way. Perineal wound closed completely twenty-two days after the operation. On April 2d he was able to hold the urine three to five hours during the day, and on an average of about three hours during the night. Has not had any of the burning pain at the base of the

bladder since the operation. For a couple of weeks after operation, patient did not have complete control of the rectum, when bowels were loose. This partial loss of sphincteric control, however, rapidly disappeared, and when he left the hospital, April 4th, control was normal.

#### Discussion.

G. Frank Lydston, of Chicago: Mr. President.—I believe that the year 1892 must necessarily go down into medical history as marking a wonderful epoch—the discovery of the prostate by the general surgeon of Chicago. Dr. Murphy has referred to me, and has stolen a great deal of my thunder.

The nomenclature of a middle lobe of the prostate is fallacious, and I protest against the term middle lobe being used. The absurdity of classifying it as a middle lobe is shown by Dr. Murphy's remarks when he referred to a case in which a pedunculated tumor was found and readily removed without the lateral lobe coming away. To speak of removing a pedunculated fibro-adenoma at the neck of the bladder and freeing the bladder at the posterior median lobe of the prostate is ridiculous. Cases in which there is no distinct tumor, but a median thickening, should not be classified as the posterior median lobe. I classify conditions or tumors of one kind or another, located in the posterior median portion of the prostate, as merely posterior median hypertrophy. I do not wish to assume a dogmatic position, but, according to the investigations of Reginald Harrison, infants have no prostates, but as they advance in life they develop prostates which can be determined.

So far as the muscular tissue of the prostate in children is concerned, it bears the same relation to the muscular tissue of the bladder wall that the muscular tissue of the cervix uteri does to the body of the uterus, and the mucous membrane of the prostatic urethra presents an appearance as though the mucous membrane of the bladder was simply drawn down through.

The term prostatectomy is a misnomer as applied to a large number of these operations. The operation does not consist, in the majority of cases, in the extirpation or resection of the prostate, but simply the removal of pathologic tissue, which is circumscribed in many instances, forming fibrous or distinctly pedunculated tumors of one kind or another. In a large proportion of instances most men, who have worked in this field, will agree with me that the term prostatectomy is a misnomer, and possibly the nomenclature of prostatectomy may be held responsible for the avoidance of the operation by general practitioners, to whom the removal of the prostate seems a formidable operative procedure, if not an impossibility.

With regard to acute retention, the essayist very clearly set forth the fact that it is the relative degree of deformity of the prostatic urethra rather than the size of the prostatic overgrowth, *per se*, that determines the symp-

toms. In cases of acute retention the mistake is made that there has been an increase of the prostatic overgrowth, an increase in bulk, shutting off the urinary passage completely. As a matter of fact, however, acute retention may be due to spasm, to acute hyperemia, superadded to organic obstruction.

Dr. Murphy made clear the necessity of early operation. I believe the statistics of radical operations upon the prostate up to date are almost worthless, in that they do not show what radical operations *per se* might accomplish under favorable conditions, but what may be accomplished under desperate conditions. The mistake, I believe, originated in the belief of the profession that prostatic hypertrophy is a senile change, and is an essential factor in the life of the young and old man. Every old man may be said to have symptoms, more or less marked, of prostatic hypertrophy. In all cases of prostatic hypertrophy of whatever variety of new growth, the conditions are laid down at a much earlier period than is ordinarily supposed, and the time at which severe symptoms manifest themselves is not at the period of beginning of the disease. And that is a mistake we all make. If we were to apply the same pretext to ovariectomy that we apply to prostatectomy, we would have poor results.

## OBITUARY.

### Hugh Marshall, M. D.

Dr. Hugh Marshall, one of the oldest practitioners in Monmouth and Warren county, died at his home on April 10, 1903.

For long years Dr. Marshall has been active in the practice of medicine in this county. In 1872 he came to Monmouth. During these years of practice he became a familiar figure all over the entire county, and succeeded in building up a large clientage, being recognized as one of the leading physicians of this entire section.

During the last few years failing health compelled him to lay down some of the active duties of his life, and he had for a number of years previous to his death been gradually relinquishing his practice. Through his long years of usefulness he had been prominent in the medical circles of this county. For some years he was coroner and was always an active member of the Warren County Medical society. He at one time was president of the Military Tract Medical society and was a member of the Illinois State Medical society.

Dr. Marshall was born in South Carolina, December 15, 1825. In 1839 together with his parents, Mr. and Mrs. Alexander Marshall, he came to Henderson county where his parents died. Beginning his education in South Carolina his common school work was finished in Henderson county. After reading medicine for some time in a private office he entered Rush Medical college at Chicago, where he graduated with the class of 1852. In 1872 Dr. Marshall was married to Matilda C. Brewer of Monmouth, who with their son Hugh survives him.



# The Illinois Medical Journal.

The Official Organ of the State Medical Society.

EDITOR—George N. Kreider, A. M., M. D., Springfield.

Official Reporters of Affiliated Societies—

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All communications should be addressed to the Editor, 522 Capitol Ave., Springfield, Illinois.  
The JOURNAL is published monthly. The subscription price is \$3.00 per annum in advance.

MAY, 1903.

## THE CHICAGO MEETING.

Ten years ago the Society met in Chicago, the president then, E. Fletcher Ingals, being as now M. L. Harris, a resident of that city. The World's Fair was then in full swing. The active work of the president had worked up the membership to the highest point in the history of the Society. The program was excellent and the Society for the first time worked in two sections. Strangely

enough the profession was at that time expressing its desire for a Board of Medical Examiners. The Chicago Medical Society at that time had about 600 members and the total number of societies represented on the nominating committee was 22, four of them being of Chicago. Wm. O. Ensing of Rutland read his first report on Medical Societies which marked an era in the organization of the profession. The total actual



members of local societies in the State then was possibly 1,800.

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Next week President Harris will preside over the house of delegates, composed of about 95 members representing 105 local societies with a membership approaching 4,400 members. The Chicago Medical Society with 16 affiliated and branch organizations will have 1,425 members represented by 19 delegates. The Society will hear its scientific papers in three sections, which will be attended by not less than 1,200 persons. It will at that time know the fate of the bill establishing a Board of Medical Examiners and will be in position to praise those securing its passage and show its contempt for the obstructionists. The Committee on Medical Societies will be able to report an almost perfect organization of the State by counties. Altogether the largest State Society in the union convening as the guests of the largest city society in the world bids fair to have the most interesting meeting in its history.

#### THE LEGISLATIVE COMMITTEE.

A residence and practice of twenty-three years in the seat of government of this State, during which we have kept in close touch with the efforts of the profession to secure legislation, enables us to speak with some degree of authority concerning the work of the Legislative Committee before and during the present session of the General Assembly.

\* \* \* \* \*

In the first place the profession has by reason of the Journal and other efforts been organized to the highest degree of proficiency for united and harmonious action. Chairman Black has been the organizer and he has searched the State from Antioch to Cairo and from Danville to Quincy to secure workers for the cause. He tabulated the

laws of every State, territory, province and district of the western hemisphere to assist in the compilation of a perfect law and barring the changes which it seemed impossible to avoid making the law will be found a model document of its kind. The history of the state of affairs which seemed to make these changes or concessions necessary would make a long and interesting story which we cannot now detail.

\* \* \* \* \*

Before the law reached the legislature, the committee met a state of affairs which would have discouraged a committee of less stability and after the bills were introduced we are sure that many another triumvirate would have given up the contest, placed the responsibility where it belonged and retired gracefully from the field. Indeed the committee were advised to do this by more than one strong leader in the Society. But our leaders never grew tired and never lacked a resource when success seemed all but impossible. Hours, days and nights have been given by them to the interests of the profession.

At this writing the fate of our bill hangs in the balance. It passed the Senate unanimously last week and was promptly reported over to the House and later referred to the Committee on Judiciary of which Mr. Shurtleff is chairman. It is understood that the chairman is not friendly to the bill, but he has promised to report it out of his committee and give the members of the House a chance to go on record for or against the measure. This is all that could be asked and we feel sure that the wishes of our fraternity will be respected by their representatives and that the bill will finally carry by quite as complimentary a vote as was accorded it in the Senate.

\* \* \* \* \*

Whether the battle is won or lost the Illi-

nois State Medical Society should be proud to have such characters in its membership as Drs. Black, Ingals and Taylor. If they individually and collectively are not accorded a rising vote of thanks, a huge laurel wreath of appreciation and a triumphant entry into the citadel of our affections at the meeting in Chicago next week then indeed may the Society be called ungrateful and honest effort be said to go unrewarded.

#### THE JOURNAL: INDEX FOR VOLUME FOUR

The present number of the Journal will be found much larger than any previous issue for reasons over which we have had no control. Two of the papers which were read at the Quincy meeting were not sent in until after the April Journal had appeared and there had been no intimation that they would be presented. In the meantime two papers, Black's and Yolton's had been accepted for the May issue and put in type. The Journal therefore will have more the appearance of a magazine than a medical journal, but owing to the valuable articles it contains we hope our readers will unite in saying that it is one of the best issues of the year.

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Owing to unusual size and necessity for haste in issuing the last number of the present volume we are obliged to defer sending out the index until next month. This, when issued, will be found more complete than any index which has been thus far furnished for this Journal.

\* \* \* \* \*

O. J. Roskoten of Peoria announces that he has a few duplicate volumes of Transactions which he would be pleased to exchange with members having volumes which he lacks.

#### FATTY OVERGROWTH OF SYNOVIAL VILLI.

The occurrence of pain, swelling and impaired function in a joint, as a chronic affection, especially in the large joints and without accompanying symptoms of some general disease, would indicate as a rule some infectious process of a chronic character; naturally tuberculosis would be thought of in many instances. Painter and Erving (1.) have called attention to a condition which although known for many years is not ordinarily considered in the differential diagnosis of tuberculous arthritis.

The hyperplasia and hypertrophy of the adipose and connective tissue in the villous formations of the larger synovial sacs has been designated as lipoma arborescens. The use of this term will no doubt be continued notwithstanding its questionable propriety, for the process whereby the growths are formed in this condition has very little in common with that operating in the development of true tumors.

Steida writing in 1896 could only find 13 cases and this included two of his own, yet these writers give the details of 7 cases observed at the Carney Hospital in Boston during a period of three years. Many diseases although uncommon at present, have passed through cycles of extreme infrequency of observation; for years succeeding their first recognition only occasional references to them may be found in the literature. It is not impossible that a similar course of events awaits this little known joint affection.

Many of the cases might be mistaken for instances of free bodies in the joint, on account of the slipping sensations and sharp pain and occasional succeeding effusion.

Single synovial villi sometimes become free in the joint and such occurrences may

or may not supervene in connection with the more general hypertrophy of the adipose tissue.

Important distinguishing features of lipoma arborescens are absence of clinical evidences of acute inflammation, the presence in some cases of a mass which in the knee joint may be found by palpation and the usual absence of much fluid in the joint. The growth removed from the knee in one of the cases reported by Painter and Erving was the size of an adult palm. The patient, a young woman, had suffered for six months and at the time of the operation complete extension of the leg was impossible; there was some atrophy of the leg; X-Ray examination was employed but no diagnosis was made before operating.

In three other cases the growths were the size of an English walnut or larger. Microscopic examination of the masses removed revealed the normal elements of the villi and in addition inflammatory changes endarteritic blood vessels and large amounts of adipose tissue. A number of observers have ascribed a tuberculous etiology to such fatty growths; Painter and Erving, however, found but little to support such a view. Removal of the overgrown villi is followed by recovery; the authors encourage exploration of the joint as a diagnostic measure.

#### MORTALITY STATISTICS OF ILLINOIS CITIES FOR MARCH, 1903.

	Popu- lation.	Death Rate.	Diph- theria.	Scarlet Fever.	Measles	Small- pox.	Typhoid Fever.
Chicago .....	1,885,000	16.94	49	30	29	8	49
Springfield..	40,000	14.12	0	0	1	1	1
Jacksonville..	16,000	21.06	0	0	0	0	1
Pontiac .....	4,286	8.04	0	0	0	0	0
Freeport.....	13,258	8.05	2	0	0	0	0

Peoria: Commissioner of Health McFadden has kindly forwarded a copy of his annual report for the year 1902. Basing his calculations on a population of 70,000, which

is probably a little high since the census of 1900 showed only 56,100 and the census of 1890, 41,024. Dr. McFadden calculates the death rate at 10.6. The population is probably nearer 65,000, which even then gives a death rate of 11.4 of which the city may well be proud. The commissioner gives much of the credit for this to the excellent water supply. There were during the year but two deaths from diphtheria, two from scarlet fever and eighteen from typhoid fever.

Jacksonville: We are unable to account for the high death rate prevailing in this city, one of the most beautiful and intelligent communities in the State.

#### State Items.

The Medical Woman's Club was recently organized in Chicago with sixty members. Sarah Hackett Stephenson of Chicago, was elected President and Henrietta Johnstone of Evanston, Secretary. Practitioners of all schools are eligible for membership.

A writer in the Chicago Daily News recently charged the State Board of Pharmacy with great laxity in enforcing the provisions of the laws. The writer seems to think that if the Board were more active the sale of opium, morphine, codeine, chloral, cocaine, carbolic acid and other deadly drugs would be more restricted. The writer holds that these drugs should not be sold to any one having the price but only on a physicians prescription.

The first annual bulletin giving statistics regarding births during 1902, under the new law was recently issued. Complete returns from all counties except Cook and estimated returns from that county gives the total number as 85,000 for the entire State.

There were reported 572 twin births, 15 triplets and 1,767 still births. The record of illegitimate births is imperfect.

The following is the per centage of births to population in the largest counties in the state, outside of Cook, basing the population on the census of 1900:

County.	Population.	Births.	Per Ct.
Peoria .....	88,608	1,388	15.50
LaSalle .....	87,776	1,738	19.80
St. Clair.....	86,685	1,064	12.10
Kane .....	78,972	1,297	16.40
Will .....	74,764	1,481	18.40
Sangamon .....	71,593	1,358	18.90
Madison .....	67,843	1,105	16.29
Adams .....	67,058	845	20.90
Vermilion .....	65,635	1,408	21.20
McLean .....	64,694	1,267	19.30



## Official Items.

### COMMITTEE COMITATAS.

The Legislative Committee hereby gives notice to each member of each local medical society in the State that there will be a meeting of the Committee Comitatas at the Sherman House, Chicago, at 10 o'clock A. M., on Tuesday, April 28th. This notice is in conformity of Section 8, of Chapter 7 of our by-laws which reads as follows:

"The Committee Comitatas shall consist of the Committee on Legislation, with all other members of the Society who wish to meet with it. The Chairman of the Committee on Legislation shall be Chairman of this committee. This committee shall meet at 10 A. M. on the day preceding the annual session of the Society and shall consider all questions of interest to the Society that may be brought before it, and its report shall be made to the House of Delegates on the first day of the annual session."

We hope there will be a large attendance at this session. Such sessions have been held annually during the last four years, and have proved to be of great benefit to the Society and have freed the general sessions of much discussion which formerly occupied the time which should have been devoted to the sections. The topic of most pressing interest and importance is the relation of the County and District Societies to the State Society and the best means of completing and strengthening our organization. This involves the question of annual dues. Every county in the State should have several representatives present at this meeting prepared to discuss these and other important topics.

CARL E. BLACK, Chairman,  
E. FLETCHER INGALS,  
L. C. TAYLOR,  
M. L. HARRIS, Ex-Officio.  
*Legislative Committee.*

## Local Societies.

The Chicago Laryngological and Climatological Association held a regular meeting Feb. 23, 1903, with President N. H. Pierce in the chair.

Geo. E. Shambaugh read a paper entitled *Otosclerosis or Spongifying of the Capsule of the Labyrinth.*

Before the tuning-fork tests were introduced as an aid in diagnosing labyrinthine from middle ear deafness, cases presenting the clinical picture of gradually increasing deafness which ran their course without any catarrh of the middle ear and in which the physical examination revealed none of the well-known marks of catarrhal inflammation of the middle ear, were diagnosed as primary disease of the labyrinth, "nerve deafness."

With the aid afforded by the tuning-fork tests, these cases were divided into two distinct groups. The first group included those cases where a shortened bone conduction and a positive Rinne showed defect in the sound-perceiving apparatus, cases of labyrinthine deafness. The second group included the cases where a prolonged bone conduction together with a negative Rinne and a marked degree of deafness for tones at the lower end of the scale showed an obstruction in the sound-conducting apparatus, cases of middle ear deafness.

These latter cases, although the Eustachian tube was normal and the membrana tympani showed none of the marks of middle ear catarrh, were classified as the sclerotic type of the dry chronic middle ear catarrh in distinction from the hypertrophic type where a more or less contracted tube together with a retracted and thickened membrana tympani gave positive evidence of inflammatory changes in the middle ear.

These cases of so-called sclerosis of the middle ear, it has long been known, do not improve under treatment, but in spite of all treatment, as a rule grow worse and worse, often terminating in total deafness.

Post-mortem examinations of cases diagnosed as sclerosis made by Politzer, Bezold, Siebenmann and others, have revealed the fact, that the pathology of this condition consists of the development in the bony capsule of the labyrinth of nodules of spongy bone replacing the previously existing ivory-like bone of the capsule.

The clinical picture usually presented by these cases of obstruction in the sound-conducting apparatus, namely, prolongation of bone conduction with markedly negative Rinne and a marked degree of deafness by air conduction for the lower tones, is explained by the fact that the newly formed bone nodules usually developed about the fenestra vestibuli, producing quite early in the disease a bony anchylosis of the stapes and the typical symptoms of obstruction in the conducting apparatus. As the disease progressed, however, and the structures of the cochlea became more and more involved, symptoms of beginning labyrinthine deafness were often found superimposed on those of the middle ear type.

A physical sign often seen early in these cases, a sign first noted by Schwartze, is a reddish lustre transmitted to the membrana tympani from a congestion of the blood vessels on the inner wall of the cavum tympani. This sign is of positive value only when it

is present, when it signifies that the condition is progressing. Its absence is of no value in diagnosis, since the congestion disappears entirely in the later stages of the diseases.

Siebenmann was the first to report a case with post-mortem findings of multiple areas of spongifying bone in the labyrinthine capsule and where the functional tests showed deafness of the labyrinthine type instead of the obstruction in the conducting apparatus as usually found.

The diagnosis of this condition in a typical case can be made with certainty. If in a case with gradually increasing deafness, the membrana tympani is found normal or with the reddish lustre transmitted from the walls of the promontory and the Eustachian tube is open, while the tuning-fork tests show loss of perception for the low tones, a decidedly negative Rinne and prolongation of bone conduction the diagnosis of sclerosis is positive. When, however, this condition develops in a case previously the seat of some middle ear disease, either catarrhal or suppurative, or when the condition takes an atypical course, as in the case referred to above, producing labyrinthine deafness, the diagnosis in most instances must remain in doubt.

Various terms from time to time have been applied to this condition based on the existing conception of its pathology. The term sclerosis of the middle ear was the term first used to distinguish this condition from the hypertrophic form of chronic catarrhal otitis media. The term was based on a misconception of the pathology of the condition, since later investigation has demonstrated the absence in this disease of a sclerotic process in the middle ear. Ankylosis of the stapes is another term that has been used and while it expresses clearly the pathological condition that produces the prominent clinical symptoms of an obstruction in the conducting apparatus often present in these cases, it is not an entirely satisfactory term. In the first place, other pathological processes besides spongifying of the labyrinthine capsule may produce fixation of the stapes in the fenestra vestibuli and in the second place, this condition of spongifying of the labyrinthine capsule may develop, as Siebenmann has found in various parts of the capsule and produce as the prominent symptoms those of labyrinthine deafness instead of the symptoms of primary fixation of the stapes. Politzer has used the term *capsulitis labyrinthi* and Siebenmann that of spongifying of the labyrinthine capsule. In a recent number of the *Annals of Otolaryngology and Rhinology* is an article on this subject referring to the process as *otitis media insidiosa*. The process is not an otitis media at all, but a disease of the bony capsule of the labyrinth which through its early fixation of the stapes often produces the clinical picture of obstruction in the sound conducting apparatus.

I have here to present a case showing the typical picture of labyrinthine deafness but where the probable diagnosis of disease of the capsule of the labyrinth without fixation of the footplate of the stapes has been made as the

condition that will best explain all of the symptoms presented.

The history of the case is as follows: Mr. T., age 27, a University student in good general health. He has had no serious illness and has never had syphilis. He knows of no deafness in any member of his family, nor has he had any ear trouble previous to the present one.

About three and one-half years ago, tinnitus began to develop insidiously in the right ear. At first it was noticed only on waking in the morning, when everything was quiet. In the course of several months the tinnitus was noticed also during the day. It was associated after a short time with slight deafness and a sensation of fullness in the ear as though the ear was stopped up. About six months after the involvement of the right ear, the same symptoms began to appear in the left ear. The tinnitus is continuous in both ears, and in the right ear is pulsating in character. He likens the tinnitus to the roar produced by the wind in a forest. The deafness has been gradually increasing, and he says it has progressed much more rapidly during the past six months. These are the only symptoms present. There has been no dizziness or vertigo.

A physical examination found the nose and nasopharynx normal, the Eustachian tube normal and patent. The membrana tympani had a perfectly normal appearance, showing not a trace of retraction or thickening. Cone of light normal. Spread over the entire membrana tympani was a diffuse reddish lustre, transmitted from the wall of the promontory.

Functional examination gave the following results: Whispered voice could be heard in the right ear only when spoken with force and close to the meatus. In the left ear it could be heard at a distance of six inches from the meatus. In the Weber test the fork was lateralized distinctly in the left or better hearing ear. The Schwabach test showed a marked shortening of the bone conduction. The Rinne test was positive for both ears. The C-fork (64 d. v.) was heard in both ears almost as long as in a normal ear, while the C-fork was shortened about 45 seconds. The functional tests gave the usual results of a typical case of labyrinthine deafness.

The age of the patient, the normal condition of his general health and the absence of any constitutional disease that might produce disease of the labyrinth, the absence, moreover, of any known cause for primary disease of the labyrinth, such as syphilis, occupation, injury, etc., the absence, too, of the characteristic symptoms of Meniere's disease, these together with the insidious development of the symptoms of tinnitus and deafness of the labyrinthine type, led me to suspect the possibility of a primary disease of the bony capsule of the labyrinth in which the spongifying process, however, did not cause primarily fixation of the stapes but had developed in the lower end of the basal coil of the cochlea producing the typical symptoms of labyrinthine deafness. This diagnosis was made all the more probable from the result of the physical examination, which, in the absence of any sign of catarrh of the middle ear, revealed on the



membrana tympani the typical reddish lustre transmitted from the wall of the promontory characteristic of otosclerosis.

To pronounce this case positively one of spongifying of the labyrinthine capsule may hardly seem justifiable considering the very limited knowledge we have regarding the possible clinical course and the possible symptoms that may be produced by this process, especially when it develops in parts of the capsule not in region of the fenestra vestibuli, as in the case of Siebenmann referred to above. From this case it has been shown that the spongifying process may develop in various parts of the labyrinthine capsule and instead of producing the usual symptoms of anchylosis of the stapes, it can produce the symptoms of labyrinthine deafness.

In the case reported here, the clinical history, together with the physical findings, for reasons stated above, would seem to justify the diagnosis of otosclerosis or spongifying of the labyrinthine capsule involving the basal coil of the cochlea and without producing anchylosis of the stapes.

**J. Holinger:** I wish to make a few remarks on the explanations made by Dr. Shambaugh in connection with the case reported by him. The red transparency of the drum-head is given as a pathognomonic sign of spongifying of the labyrinth, still I have under observation a woman in whom this symptom is very pronounced, yet her only affection is tinnitus thus far. All the tuning-fork examinations show normal conditions.

I have doubts whether we can make a diagnosis of sclerosis or spongifying of the labyrinth in all cases where we have this red transparency of the membrane from injection of the promontory. My doubts are based on this case which I have observed for more than a year.

Furthermore, it is stated that the disease begins between eighteen and twenty-two years of age. My patient is now twenty-four years of age, and the pathological changes ought to be more pronounced at that age.

As to the differentiation between the limits of the labyrinth, there has been some change in our views recently, mainly based upon the nutrition of the parts. In the *Archiv fur Ohrenheilkunde* you will find an article in which it is stated that all the blood vessels running through the capsule of the labyrinth end sharply at the inner limit of this capsule they do not enter the membranous labyrinth. So if we make a differentiation between labyrinthine and middle ear disease, not at the mucous membrane of the middle ear, but at the limit between the membranous labyrinth and the bony capsule, we will probably approach more closely the real facts. We have to consider the condition of the nutrition more important than the macroscopic view.

Furthermore, the deafness in sclerosis is not progressive under all circumstances. It is stationary in many cases, and all authors state that, as a rule, if we leave the patients alone they have enough hearing left for conversation. The deafness does not increase until the advent of old age.

As to capsulitis labyrinthi, there is a good deal of controversy going on as to the inflammatory nature of the spongifying process of the labyrinth. So far, no actual proof has been brought forward that the process is an inflammatory one, but just the opposite. Proof has been advanced that the oldest foci of spongifying are in the depths of the bone, and there we cannot expect any inflammatory process to establish itself, if it should depend upon infection of any sort.

**W. L. Ballenger:** I simply rise for information. I have been searching for a case of "Spongifying of the Labyrinth" for more than two years, and so far I have not been able to satisfy myself that I have seen such a case, nor have I had one demonstrated to my satisfaction by others. Dr. Shambaugh reports a case in which there is positive Rinne, loss of hearing for high tones, and reduction in hearing by bone conduction, etc. I want to ask Dr. Shambaugh how he differentiates these cases from other diseases of the labyrinth. Why may this not be some other affection of the labyrinth, say chronic hyperasemia, as well as a rarifying osteitis, or a spongifying of the bone of the bony capsule? I would like to have him clear up this point for me if he will. Understand me, I do not doubt there is such a disease as Spongifying of the Labyrinth, as the microscope has shown it, and I am not saying that the disease cannot be diagnosed in the living subject, but I simply state that so far I have been unable to recognize such a case. They have all presented some of the objective signs of middle ear disease, or of fixation of the stapes. As we all know fixation of the stapes may be due to other causes than spongifying of the bony capsule of the labyrinth, hence this condition alone does not necessarily point to spongifying.

**Dr. Shambaugh** (closing the discussion): In reply to the point made by Dr. Holinger, in regard to the blood supply of the capsule of the labyrinth, I will say that I cannot see how this alters in any way our conception of the pathology of spongifying of the labyrinthine capsule, or our conception of how the symptoms are produced. Many years ago Adam Politzer stated that he had discovered connections between the blood vessels of the labyrinth and those in the mucous membrane over the promontory in the cavum tympani. This anastomosis of the blood vessels has never been verified by other observers. The recent work on this subject, to which the Doctor referred, is an article in a late number of the *Archiv f. Ohrenheilkunde*, in which the position taken by Politzer is refuted, and the point is made that the blood supply to that part of the labyrinthine capsule, which enters into the formation of the promontory, comes entirely from the blood vessels of the cavum tympani. This view tends to explain why, in the spongifying of the bony capsule of the labyrinth, we so often find a marked congestion of the blood vessels over the wall of the promontory.

The remark that cases of oto-sclerosis take an irregular course applies, it is true, to a few cases where we can note intervals during which the process is evidently progressing, and



others where it is apparently at a standstill. The character of the process of spongifying that is typical, however, is the insidious development with constantly increasing symptoms of tinnitus and deafness. The tinnitus often precedes the onset of deafness by several years.

The answer to the question asked by Dr. Ballenger as to how this case can be diagnosed from labyrinthine deafness due to other causes has been given in what I have already said. The history of the case excludes many of the usual causes of labyrinthine deafness. The insidious development of the disease excludes other types of labyrinthine deafness that are likely to appear at the age of this patient, such as injury, Meniere's disease, etc. The case lacks, too, the typical symptoms that are found in many cases of labyrinthine disease. All of these facts, when taken in connection with the marked congestion of the blood vessels over the wall of the promontory, a symptom that does not occur in labyrinthine disease due to other causes, makes the diagnosis of spongifying of the capsule in distinction from other types of labyrinthine disease reasonably certain.

**C. Beck read a paper entitled The Use of Paraffin in Speech Defects with Presentation of a Patient.**

The scientific study of defects of speech was first pursued by Kussmaul in 1878. Up to this time the treatment of this condition lay in the hands of charlatans et cetera. The study was quickly taken up in every part of Europe and America and by this time we can mention a score of very prominent specialists in this science. Among the most renowned are Biaggi of Mailand; Chervin and Olivier of Paris; D'Ercole of Turbin; Greenbaum of Dresden; Gutzmann and Liebmman of Berlin; Halle of Munich; Miele of Grant; Loewy of Charlottenburg; Oltuszewski of Warsaw; Shrank, Weil and Coen of Vienna; Jank of Prague; Makuen of Philadelphia and Winkler of Bremen. Not only these, but many a laryngologist and general practitioner has of late busied himself with the study of this subject, so that today we may read splendid investigations and a good report in literature.

Numerous classifications have been devised by the authors: One by Makuen<sup>1</sup>, who divides the varieties into two great classes,

- (a) Those originating centrally, and
- (b) Those originating peripherally.

We have, however, frequently both these conditions mixed.

The most complete and practical division has been made by Coen<sup>2</sup> as follows:

- 1, Stutterers
- 2, Stammerers.
- 3, Rhinolalia.

(a) Due to obstructive conditions to the air and sound.

(b) Due to conditions allowing the escape of the air and sound.

4, Intellectual deafness. (Horstummheit). Patient can hear his speech and believes it to be correct in the enunciation, whether it be so or not.

5, Speech defects due to pathological conditions of the nervous system, as idiots, etc.

The patient whom I present today belongs to Class 3, division "B", namely, Rhinolalia due to conditions allowing the escape of air and sound, and I will therefore confine my remarks to this class particularly.

The cases are divided into **congenital** and **acquired**, the former are the many forms of cleft palate, hare lip, perforated pillars, malformation of the uvula, congenital absence of some of the palatine muscles. The acquired are those resulting from diseases such as syphilis, tuberculosis, diphtheria and other ulcerative processes. Those of traumatic origin, or those following bad results of operations for cleft palate. Further, those of paresis or paralysis following infectious diseases, in particular diphtheria. Marked adhesions of the pillars to the base of the tongue, as following operations on the tonsils. Shortening of certain muscles of the tongue, as spastic contractures; atrophy, partial or complete of the muscles of the palate, tongue, buccal and the mouth due to the faulty use of these organs in speech. This last named condition is present in my case. Mauken<sup>3</sup> describes a case very much the same as this one, but due to somewhat different conditions.

**History:** Eva E. 20 years old, born in Russia, was dropped from her mother's lap during a fire alarm. Her oldest sister states that previous to the accident she could not talk and when she began to speak afterwards it was intelligible to no one except the parents and sister. There is nothing in the family history, nor did she have any diseases of childhood which could have any connection with this speech defect.

Nothing was done for her until at the age of fourteen, when she consulted Prof. Hering of Warsaw, who she says burned something in her nose, but she could not keep up the treatment on account of lack of means, and after three treatments stopped. She consulted three other physicians in Russia later, but they could do nothing for her. The last one advised her the making of a plate by a dentist. At the age of eighteen she came to America, visited many clinics and was found to be an excellent subject for post nasal examination, on account of the rigid palate. Any novice could with ease examine the post nasal space, but for her faulty speech nothing was done. She consulted Dr. Ingals, who recommended a school equipped for the purpose of treating speech defects. She attended this school for a short while, but here also the lack of means prevented her from keeping it up.

She consulted me first at the clinic March, 1901, and I found the following conditions:

A well developed young woman, bright looking, but sadly lacking in education. Could neither read nor write except Jewish and spoke a poor German. She had the characteristic speech of a rhinolalia.

**STATUS:**

**Nose.** Right. The middle turbinal body hypertrophied, inferior turbinated atrophic. Deviation of the septum to the right.

Left. The same condition of the turbinated as on the right and the septum has a sharp dent near the floor of the nose.

**Post Nasal.** A small pad of adenoid, a chronic catarrhal condition of the mucous surfaces, the posterior ends of the middle turbinated somewhat enlarged; the oropharynx and larynx also chronically inflamed;

**The Tongue** is thick and moves clumsily.

**The Velum** moves only slightly on phonation and it is not possible to bring it against the



FIGURE 1.

posterior wall of the pharynx either voluntarily nor manually; i. e., it is too short. Liquids pass up at times to the nose and the patient is not able to gargle.

A test by the galvanic current proves that the neuro-muscular apparatus of the palate was intact, but feeble in its action.

The **teeth** are all in good condition except the right first bicuspid, which is absent. The articulation is fairly good. The **buccal muscles** and the **orbicularis oris** are poorly developed.

The **Lungs** are normal but breathing is shallow and when she speaks it is mostly with the effort and the use of residual air which keeps the pectoral and abdominal muscles in a rigid condition.

Otherwise she is perfectly normal.

Another factor in this case is the condition of intellectual deafness i. e., she believes that she speaks all right, the same as you or I, and when I would imitate her speech she would not believe that she spoke that way.

The treatment of this case was a very tedious one. In fact, it still is, for she must be constantly reminded when she makes a mistake or else she is liable to fall back into her old way of talking.

After six months of massage, electricity, exercises of the soft palate, no noticeable change was produced and I concluded to drop the case. I sent her to a school for children with defective speech, and after one month the teacher returned with her saying that she could do

nothing with her. I then consulted Dr. Brophy, who advised the use of an artificial velum or a diaphragm, (Figure 1) which was made by Dr. Bullard. This did not improve her speech at all; only the timbre of the voice was strengthened somewhat.

I now contemplated the lengthening of her soft palate by a plastic operation, after the method of Gussenbauer, when reading in a Vienna journal the article of Gersuny, Moskowicz, in which he describes the use of paraffin in a similar case. That is, a short palate in consequence of a staphylorrhaphy.

This made me very hopeful and I concluded to try it. Not knowing what a wonderful result I might obtain by this new procedure, I had made a record of her speech by the phonograph. A few days following when I unwound the cylinder into a talking machine and let her hear her own voice, she was very much downhearted because this was the first time in her life she heard how badly she spoke. This

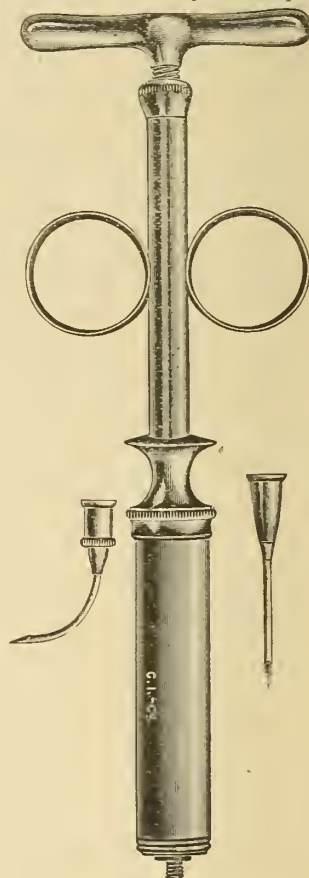


FIGURE 2.

suggested to me another method of treatment, that is, of her intellectual deafness.

In July, 1902, the patient was placed on a table with the head hanging over the edge, after the parts had been cleansed by post nasal douche and cocaineized with a 20 per cent solution. (Figure 2.) Filling this syringe which has the following necessary principles:

1st. All metal.

2d. The piston moves by screw movement, allowing the paraffine to flow out gently and in a semi-solid form. At the same time, being able to express any consolidated paraffine from the needle point.

3d. A cone-shaped termination of the barrel, as suggested by Dr. Suker, to remove any unnecessary obstruction to the outflow of the paraffine.

4th. A short, curved needle, with quite a large calibre, except at the point of insertion, preventing a too rapid cooling and hardening of the paraffine within it.

5th. A long attachment to the piston, so that the posterior wall of the pharynx could be reached.

With 15 c.c. of paraffine having a melting point of 120 degs. F. (Eckstein); and of this about 2 c. c. were injected below the mucous membrane on the left side of the posterior wall of the pharynx, on the plane where we would expect the soft palate would come in contact with the pharynx. Ice cold water compresses were applied for a few moments to this part and patient was instructed not to swallow nor speak in order not to change the position of the paraffine until it thoroughly hardened.

For about twenty-four hours patient had some pain in the side of the neck, particularly on motion, and a hard lump the size of a small hazelnut could be felt.

One week later an injection precisely the same was made on the right side, and the same care taken as before. A great deal more pain was felt this time after the injection, which I believe was due to the fact of injecting the paraffine deeper in the tissues.

Two weeks later a third injection, this time using 4 c. c. instead of two, in order to fill out the groove formed by the two previous injections. There was but very little pain following this last operation, but a constant desire to swallow and to clear the throat for about three days. The re-action of the tissues about these masses was not very great. Patient told me that she attempted to insert the plate, but this was impossible, for it struck against these masses of paraffine.

At this very time I noticed the first improvement in her voice, when she uttered the word "plate." Previous to the injections she could not say the consonants b, p, m, g, l, n, and others, but she can pronounce them now quite correctly. The regurgitation of the fluid has stopped and she can gargle without any difficulty.

Since August, 1902, I have been drilling the patient according to the method of Liebmann<sup>5</sup>, in connection with all possible adjuvants, such as breathing exercises, massage and electricity.

The improvement is very satisfactory. The patient can talk quite plainly; when speaking slowly, otherwise she winds up the sentence in the old-fashioned way.

The impediment to rapid progress is the inferior education she possesses, as well as the lack of means and time she is able to devote to this trouble. She is confined to her work all day as a shop girl.

I have secured for her a private school teacher whom I instructed how I want her to talk and she has just completed the first reader. She uses the phonograph to overcome the intellectual deafness.

It is true that the phonograph does not reproduce the voice or sound perfectly, but it does not flatter one by any means, so that the patient need not fear of becoming conceited.

I present this case at this time because the patient tells me that she begins to feel difficulty to talk the old way, and I desire you to hear her while it is still possible for her to demonstrate the difference in her speech. One fact she knows, that she has more power to speak:—she calls it more air in the mouth, and feels something pressing against her palate. The soft palate can be pressed backwards to meet the protuberance on the posterior wall of the pharynx with great ease, but the palatal motion is still very limited.

#### References:

1. Makuen—Therapeutic Gazette, Dec 15, 1896.
2. Coen—Wiener Klinische Rundschau.
3. Makuen—Philadelphia Polyclinic, Vol. V. May 16, 1896, XX.
4. Moskowicz—Wiener Klinische Wochenschrift, 1901, No. 15.
5. Liebmann—Vorlesungen über Sprachtoerugen, Heft 5.

**William L. Ballenger:** I do not rise to discuss this paper, but I wish to say that I saw the case when Dr. Beck took charge of it. There has been a remarkable improvement in her speech since that time. Then it was almost unintelligible to me, except upon frequent repetitions. How much the improvement in her speech is due to the paraffine injections, and how much of it to careful training, I am unable to say. But the fact remains that there is great improvement.

**Dr. Beck** (closing the discussion): I brought this patient here for the purpose of demonstrating the educational side of speech defects. I stated in my paper that I drilled this patient in the matter of speaking before operation. The teacher who drilled her said it was impossible to do so in such a manner as to overcome the defect, the space between the posterior margin of the palate and the posterior wall of the pharynx was too large. Perhaps the injection of paraffine facilitated somewhat the improvement in speech, but the educational feature is undoubtedly the prime factor in this case. I would say, that all patients after having undergone the operation of staphylorrhaphy do not speak correctly until they have been educated to do so, and that is the point in my case. I look upon the paraffine as only an adjunct in the treatment, that is after the post nasal space could be separated from the oral cavity by the closure of the palate, the education of speech was made possible.

J. Holinger reported a case of Tuberculosis of the Nose.

Otto T. Freer read a paper on Result of Microscopic Test in a Case of Nasal Perichondritis Shown at the Last Meeting, with a Review of the Diagnosis of Nasal Tuberculosis.



At the last meeting of this Society I presented a case showing the following peculiarities. The patient's disease was confined to the nasal vestibule and cartilaginous septum. The latter presented a large perforation which reached back as far as the vomer and up to the perpendicular plate. It had for the most part, smooth, cicatrized borders with eroded places but displayed no ulceration. The triangular or superior lateral cartilages of the external nose were thickened by chronic perichondritis, while the right alar cartilage had disappeared, apparently by absorption and the wing of the nose was drawn inward and upward nearly closing the right nostril and giving it a notched appearance. The septum behind the perforation, the turbinated bodies, nasal floor naso-pharynx, pharynx and larynx were intact. A view of the interior of the external nose showed the mucosa of the nasal vestibule to be contracted, thickened and deformed by a sclerosing, cicatrizing process evidently due to some form of chronic inflammation which was, at the time of inspection at least, not accompanied by any ulceration or any pathologic tissue characteristic of any usual morbid process. I surmised that the trouble had a possible traumatic source on account of the rough way in which the patient had removed scabs from his nose ever since he had had an operation for septal deflection in 1894. He often used a nail head for the purpose and only the other day pushed a needle up into the mucosa of his left nostril to let out some imaginary discharge. I admitted that a syphilitic condition with perichondritis of the cartilages of the external nose could not be positively excluded, especially as syphilis need not extend beyond the cartilaginous skeleton of the nose, but could see no ulceration of tissue characteristic of syphilis and there was no evidence that the disease had ever been contracted. As the patient claimed that the 'disease of his external nose had only existed since October it would be reasonable to suppose that were his disease syphilitic there would be some active ulceration characteristic of syphilis present, but none was visible.

It hardly seemed possible to me that the disease could be thought tubercular, but to my surprise Dr. Holinger pronounced the case unmistakable tuberculosis of the nose and not an unusual but a typical case that is, an ordinary form of the disease. He did this from mere inspection of the gross appearances of the disease and stated that the chronic deforming sclerosis of the interior of the external nose presented by the case sufficed to stamp it unmistakably as tubercular and that it was not necessary that the products of tuberculosis, tubercles and ulcers as usually seen should be present. In other words, in order that the case should be tubercular it was not necessary to find tuberculosis. Dr. Holinger based his argument upon his memory of an article whose author and source he could not recall and upon his observation of a case which he said duplicated mine. As these views did not at all accord with my conception of tuberculosis of the mucous membrane or skin I decided to go

more fully into the matter and to see whether Dr. Holinger's idea of typical tuberculosis of the nose agreed with that held by those who have written upon the subject. I reviewed therefore the literature of the subject quite fully for the past ten years in English and German publications and the abstracts of papers in other languages as presented by the Internationale Centralblatt fuer Laryngologie and found that my case far from being in accord with the descriptions of characteristic tuberculosis or lupus of the nose did not have its parallel in the literature of the subject.

There exist a number of carefully written articles on nasal tuberculosis and lupus, both affections usually being considered together. The most complete are those of Hans Koschier, including a report of 18 cases of nasal tuberculosis and 6 of lupus observed in Stoerk's clinic, the publication of Heryng with a collection of 42 cases of tubercular tumor and 48 of tubercular ulceration, and that of Maximilian Herzog, with a report of ten cases and the tabulation of 80 cases. The types described by the author are the tubercular tumor, tubercular infiltration, tubercular ulceration, lupus infiltration and ulceration. The tubercular tumor is the most frequent manifestation of nasal tuberculosis being present in more than half of the cases reported. It usually exists as primary tuberculosis and presents as a soft, grayish-red friable growth of fairly smooth surface, that bleeds readily when touched. These tumors almost always grow from the lower and anterior part of the cartilaginous septum. Tubercular tumor can of course be excluded in my case.

In regard to the second type of the disease, the ulcerative form of nasal tuberculosis Koschier and Heryng state to quote Koschier, that it "occurs only, as the authors without exception emphasize, in individuals who have tuberculosis elsewhere," that is, it is secondary tuberculosis. This is the only form of nasal tuberculosis that my case could possibly resemble and of it Dr. Holinger said that it represented a form that was primary and tended to remain local, a contradiction of the authorities as I have reviewed them. The ulcerative type of nasal tuberculosis also generally starts upon the cartilaginous septum. Koschier says: "Nasal tubercular ulceration anatomically presents the usual characteristics of tubercular ulcers of other mucous membranes." Tubercular ulceration of the nose does not therefore display a unique type of which my case was supposed by Dr. Holinger to be an example, but is like tuberculosis in other parts of the body. I quote Koschier further: "Preceding the stage of ulceration there is a short stage of tubercular infiltration which soon degenerates into the ragged ulcers with infiltrated base and border characteristic of tuberculosis. These ulcers usually are hidden by adherent crusts and when these are removed grayish-white nodules may be seen corresponding to the separate collections of tubercles. The edge and floor of the ulcer is apt to have rounded depressions which give it a gnawed out appearance. The nodules keep continuously forming at the border of the ulcer and break-

ing down. Before the process has had time to destroy much bone or cartilage the patient dies of tuberculosis.' The ulcers usually spread onto the nasal floor and onto the lower turbinated body. Sprouting masses of granulations are also described.

This picture does not in the least resemble the findings in my case. The patient has no tuberculosis elsewhere. There are no ulcerations, infiltrations or granulations visible.

Dr. Holinger made the point that tuberculosis of the nasal vestibule is not tuberculosis of a mucous membrane, but cutaneous tuberculosis as the inside of the external nose is lined with skin and not with mucous membrane, and the ulcerations described are characteristic of tuberculosis as it appears upon the mucous and not the cutaneous lining of the nose. The disease in my cases is, however, not at all confined to those portions of the vestibule and septum lined with skin. The perforation of the septum extends as far back as its bony portion and therefore well into the mucous surface lined with ciliated epithelium and this perforation is certainly a part of the disease process and the oldest part and should present characteristic changes such as are shown in tuberculosis of the mucous membranes. It is also incorrect to speak of the lining of the nasal vestibule as composed entirely of skin. This covers, according to Zuckerkandl, only its lower portion a little above the inner surface of the alar cartilages while the upper part of the vestibule is lined by mucous membrane and as the disease in my case extends as high as the nasal bones we should also here have the changes characteristic of tuberculosis of the mucous membrane and not of the skin, were the disease tubercular.

Dr. Holinger first spoke of my case as nasal tuberculosis, later he referred to it as the form of tuberculosis called lupus. This was a distinct contradiction of his first diagnosis for though pathologically lupus and tuberculosis are the same disease, clinically the authors agree that both differ greatly. They all regard nodules, warty infiltrations and ulcerated nodules as characteristic of lupus.

Koschier does not describe hard dense cicatricial masses such as my case presents as the result of lupus but found in his cases small delicate scars. He discovered tubercle bacilli in the nodules but not in great numbers.

Jarisch, who has written the work on dermatology in Nothnagel's Handbuch, states that lupus within the nose appears in the form of soft red or gray granulations with purulent ulcers, papillary excrescences and mulberry like proliferations.

The description of Friedrich Hahn comes nearest to what Dr. Holinger thinks that he has found in my case. Hahn emphasizes what all authors do, that lupus often is concealed in the anterior part of the nasal interior and is supposed to be merely an eczema or chronic rhinitis until the external nose is attacked and lupus efflorescences appear upon its skin. Inspection then shows perforation of the septum, the borders of which are surrounded by a wall of granulations that bleed easily. At the beginning the diagnosis is hard, as one seldom

sees red firm lupus nodules on the nasal mucosa, but rather infiltrations. The extension of the disease to the skin outside of the nasal cavity with destruction of the external nose comes as a surprise. In Hahn's cases the lupus began in the form of chronic eczema of the vestibule with diffuse infiltrations and later proliferations of hypertrophic granulations. Though this description comes nearest to the appearances in my case it shows no lupus efflorescences upon the skin of the external nose though it has had abundant opportunity to extend to it and merely distortion and not destruction of this organ, and no granulations or infiltrations.

Koschier found lupus nodules in all cases, often coalesced in the form of large warty infiltrations. Hollaender states that destruction of a coarse order, as shown upon the septum in my case is not characteristic of lupus vulgaris. He describes lupus of the nasal mucosa as marked by crust formation rhagades, lupus ulcers and tumors. In the later stages he states that lupus of the soft palate, pharyngeal wall, epiglottis and larynx are almost never absent. There is no such involvement in my case. The lips, gums and conjunctiva may be also involved. In extreme the nose becomes a spongy tubercular mass that is broken in by the first trauma. This is not in accord with the sclerosed condition shown in my case and regarded by Dr. Holinger as typical of lupus.

Lupus is generally a disease of early life but in rare cases may begin at any age.

For the purpose of histologic diagnosis I removed a piece from the only region of the nasal interior that could have formed a possible seat for tubercles, the fistulous pocket in the mucosa behind the left triangular cartilage. Examination of this very firm substance shows merely very dense connective tissue. No lymphatic tissue, giant cells or even round cell infiltration. Therefore histologically tuberculosis has not been found in my case. The sentiment of the writers is that the existence of nasal tuberculosis or lupus is not proven without a microscopic test, as the affection is too rare to acquire experience in making a naked eye diagnosis, in fact is one of the least seen nasal diseases. Koschier found bacilli in the tissues of both lupus and tubercular cases.

As dermatologists are more familiar with lupus than others I showed my case to James Nevins Hyde who inspected the nose within and without and declared without hesitation that there was neither tuberculosis nor lupus present. His reasons beside the impression gained by inspection were:

The occurrence of the entire disease since the year 1893, a period of time too short for such extensive destruction of the septum to occur in lupus. He quoted Hebra in stating that in cases in which lupus developed after the thirtieth year there was always a history of tuberculosis in the first decade of life.

Forchheimer of Copenhagen, Finsen's assistant, states that perforation of the septum very rarely occurs in lupus of the nose.

The absence of lupus nodules in the nose and in other parts especially the gums disproves the existence of lupus. The process from last autumn until now as a result of which



the nicking of the right ala has occurred is far too rapid for the advance of lupus.

I have not found the adherent crusts described as characteristic of lupus and tubercular ulcers in my case although the patient speaks of removing them. In fact during my long observation of the case I have never seen a crust.

Specific treatment has had no decided effect on the affection and I am still of opinion that chronic simple sclerosing inflammation may be the cause of the patient's trouble, the cause of which is obscure and possibly traumatic. The loss of the right alar cartilage is not due to a cicatrized ulceration as I thought at first, but frequent inspection has shown me that it was caused by absorption of the cartilage and consequent loss of support to the ala, which has suffered some shrinkage. The insertion of an Ash tube will nearly restore the form of the wing of the nose, which is hard and thickened. I do not think that a positive diagnosis can be made in my case, but feel that I have definitely excluded tuberculosis of the nose and think that the difference of opinion in regard to the diagnosis has aroused interest in the subject and I hope that the large material at the command of the members of this Society will furnish us some cases for study.

William L. Ballenger opened the discussion on these papers. He said:

I have taken a cursory glance of the literature for the past sixteen years in order to learn the various points of view from which this disease is regarded. I have been especially interested in the great variety of clinical descriptions, and have arrived at the conclusion that if one is to depend upon the published descriptions of the tubercular lesions of the nose that it will be impossible to find a very general unanimity of opinion as to its clinical manifestations. Didactically the writers agree in a general way in classifying the manifestations of nasal tuberculosis under four general headings, namely:

- (a) Tuberculoma,
- (b) Tubercular ulcer,
- (c) Scleroma, and
- (d) The pedunculated or polypoid type.

When it comes to the description of cases under any one of these general types there is such a great variety of appearances that it would be very confusing to one who had seen but few of these cases, if he should attempt to find in it the varying symptoms described by the writers. He might, perhaps, be able to find one author who would describe the disease in such a way as would seem to fit his case, while the others would give a description which would not at all describe it. All authors practically agree, that, in the ulcerative type, certain characteristics are, or should, be present. For instance, they usually say that the ulcer is limited to a definite area, from the size of a split pea to a 25 cent piece, oblong in shape, the edges being either raised or everted and sharply cut; the color being pinkish gray after the muco-pus has been removed. They also say that there may be small tubercular nodules, yellow in color, at the periphery of the ulcer, and that they usually soon ulcerate.

They are also pretty well agreed in stating that the location of the ulcer is usually on the anterior portion of the septum. Additional statements are made to the effect that the tubercular nodules are not always present, nor are the other symptoms as described above; but that they may vary within a wide range of manifestations. They also tell us that the presence of laryngeal or pulmonary tuberculosis will aid in arriving at a diagnosis.

In regard to the tuberculoma, there is not such a wide difference in the description, although even here it would often be impossible to make a diagnosis from the mere clinical manifestations of the case. In the reports given it is even shown that microscopical sections of tubercular nasal lesions are not always characteristic of this form of infiltration, but if the characteristic tubercular cell arrangement is found that diagnosis is settled. The reports also show that bacilli are not always found in the section nor in the secretions; that is, staining the sections and secretions does not always show them to be present. Other cases reveal the fact that, whereas, the primary lesion in the nose does not reveal bacilli upon staining, the subsequent ulcer or tumor appearing in the pharynx or larynx may show bacilli to be present. One very interesting case was reported by Juffinger: Age 21, reddish growth on right side of nasal cavity associated with lupoid nodules on face and nose. The growth contained Koch's bacilli. A curious thing about this case was that twelve brothers and sisters of the patient had died of tuberculosis. In Hajek's case no bacilli were found, but a tumor appearing in the pharynx at a later time contained them. He remarks that bacilli may or may not be found upon microscopical examination.

Seifert reviewed 38 cases, in 19 of which no signs of tuberculosis were present in other organs of the body.

Grossard reports a case of mixed syphilitic and tubercular disease of the nose, while Wagner reports that control experiments proved the identity of lupus and tuberculosis.

While it is not common to find the tubercular bacilli in the nasal discharge from man, Shurley reports the case of a monkey in which the bacilli were found in the discharge. Upon post mortem examination he found no signs of disease in the other organs.

H. Krause reports a case in which Koch's tuberculin was used and was followed by a reaction of 104° F. The first five injections were followed by a severe re-action and the sixth by improvement.

Chiari reports that he only found six cases of nasal tuberculosis in 6,000 cases treated by him in four years, thus showing the disease to be comparatively rare so far as his observation goes.

Simonl describes Pseudo lymphoid lupus, which is a polypoid and pedunculated tumor of tubercular origin. This is caused by the most attenuated tubercular bacillus affecting the nasal mucous membrane.

Orlandi makes an interesting review of a case affecting the cribriform plate and ethmoid bone and the meninges. The viscera were



negative. Pus was injected into guinea pigs and bacteriological examination showed tubercle bacilli. In an editorial by Sajous he makes this significant statement, "Judging by the number of cases reported, nasal tuberculosis is by no means as rare as was formerly supposed."

Lennox Browne and others state that bacilli may be found in the deep scrapings when they cannot be found in the superficial tissue.

Finally, W. Miligan of Manchester says in regard to the diagnosis of tuberculosis of the upper respiratory tract, that the best and most reliable means of diagnosing is by means of inoculation experiments.

In a case reported by me two years ago my diagnosis of nasal tuberculosis was confirmed by the inoculation of a guinea pig in which, after four weeks, tuberculosis of a very virulent type developed.

It would appear from this hasty review of a small portion of the literature upon this subject that nasal tuberculosis may manifest itself in multitudinous ways, and, it is no wonder that the physician who only occasionally sees a case is in doubt as to the diagnosis. The written description by any one writer will not convey a good description of any other case. It is only in the ulcerative variety where the little yellow nodules or tubercles are present at the periphery of the ulceration that a positive diagnosis can be made without resorting to the use of the microscope, or to injection of tissue into the guinea pig, or, if tuberculosis in other organs is excluded, to the use of Koch's tuberculin. It is not probable that in more than half the cases of true nasal tuberculosis, in which the scrapings are examined microscopically that the bacilli will be found. Therefore, this test, if negative in character cannot be regarded as conclusive. The injection of some of the diseased tissue in guinea pigs, is, perhaps, the most reliable test at our command if proper precautions are taken to wash the surface of the tissue so as to exclude the accidental tubercle bacilli which happen to be lodged upon the surface.

In conclusion then, I would say, that nasal tuberculosis is a disease which can occasionally be properly and positively diagnosed by the (a) clinical appearance of the growth or ulceration and that more rarely by (b) microscopic examination of the discharge and scrapings of the tissue. (c) The test next in order is that of the injection of tuberculin with a view of eliciting the re-action peculiar to tuberculosis. It is obvious, however, that this test can only be of value in those cases in which the disease has been present in the nose for many years and careful examination of other organs of the body have shown them not to be involved. (d) The fourth and most conclusive test then, is the injection of the diseased tissue into guinea pigs, in which, after from three to six weeks, the post mortem examination should be made to determine whether or not the inoculation has produced tuberculosis.

Henry Gradle was asked to say a few words on the subject. He said: I can only add from my limited experience to the opinion expressed by Dr. Freer that tuberculosis of the nose is very rare. The description of it in

my book is based largely on the literature. I have only seen one sure, and one doubtful, instance of it myself. From what I could gather from the literature and descriptions, such cases are exceedingly rare. The case Dr. Freer has shown does not answer to the clinical descriptions of tuberculosis.

**Homer M. Thomas:** Confirmatory of the remarks made by Dr. Gradle, relative to tuberculosis of the nose, I might say that I have been studying my cases carefully for over twenty years, and I have never seen them simulate tuberculosis of the nose, hence its extreme rarity is unquestionable.

**Joseph C. Beck:** I was very fortunate during my stay in Vienna to see Hazek show three cases of tuberculosis of the nose. He proved they were such by the points and methods emphasized by Dr. Ballenger. Those cases did not look anything like either one of the cases shown here. In the cases I saw the lesions were polypoid in character, but purely tubercular. The three cases were followed out, and tuberculosis of the nose was verified by microscopical and bacteriological examinations, also by injections of tuberculin. Each case gave the re-action to tuberculin, and one case gave a re-action of 106, but his usual temperature was only 100½° or 101° in the afternoon. Bleeding on touch was marked in one case where the polypoid variety of lesions was present.

**J. Holinger:** I thank Dr. Ballenger for his support. As to the fact itself, I was requested by the President at the last meeting to bring literature in regard to tuberculosis of the nose, and, if possible, the patient I spoke about, which I did.

**Dr. Freer** (closing the discussion): I consulted Professor LeCount in regard to the guinea pig test and he told me that it was so unreliable as to be misleading. Accidental contamination of the surface of the nasal mucous membrane with tubercle bacilli is so common that quite possibly a guinea pig would become tubercular as the result of inoculation with the suspected tissue even if this contained no bacilli in its substance. After having Dr. Hyde declare my case not tubercular and after the negative findings of the microscopic examination I did not think the tuberculin test necessary but if I can get the consent of my patient I shall try it.

**Myxoma. Presentation of Specimen; Exhibition of Microscopic Slides; History of Case, and Operation.**

**Homer M. Thomas:** The tumor which I wish to present is a myxoma. It weighs 15½ grains, Troy. As you are all aware, the most common form of nasal tumor is that of myxoma. It is the lowest grade of adult connective tissue tumors. As regards the etiology, there are many theories, but as yet there is no accepted conclusion with reference to the cause of myxoma. My personal belief is that it arises from a hyperplastic exudate within the nasal mucosa, depending upon changes produced by chronic inflammation. Myxoma is a very common tumor of both the nasal and post-nasal passages. Myxomata are frequently associated with infectious processes or lesions of the acces-

sory sinuses, associated with necrosis of the ethmoid cells and may originate in these sinuses. Age varies, but they are usually found between the ages of fifteen and thirty years. They may be single or multiple. Tumors of the sessile variety are much harder to remove and are more likely to recur and become the seat of sarcomatous growth. Their size is influenced by barometric changes. As regards the site of them, they originate from the middle turbinated bone. In color they are gray and translucent. Papillary, edematous, polypoid tumors are irregular, and have wave-like projections, with elongations of a row of epithelial cells on the surface. The size varies from a pin-head to include almost complete occlusion of the naso-pharynx. The tumor passed around for your inspection was attached to the middle turbinated bodies of both sides of the septum, and extended backwards into the naso-pharynx and downwards, until it was easily seen at the superior border of the soft palate without elevating the palate.

The pathology of these tumors consists largely in a sac of connective tissue with epithelial covering, containing fluid of a highly mucoid character, spindle-shaped cells and fine trabeculae of connective tissue. The blood vessels are clearly outlined in the mucous membrane lining the tumor, and the blood vessels rarely ever penetrate the tumor mass.

Under the microscope this specimen shows many elongated, branching cells, the prolongations of which intercommunicate freely in a homogeneous mass. They are analogous to Wharton's jelly, and tissues of the lower type. Interwoven through this almost structureless mass is a firm connective tissue stroma, more dense in places, especially near the surface of the tumor. The fibrous tissue shown here is often misleading, and a diagnosis of fibroma is made in just such types of tumors as this, owing to the amount of this connective tissue. The blood vessels are quite numerous throughout, being most plentiful where the connective tissue is densest; while in the gross specimen hemorrhage is of little or no consequence. Under the microscope the question of the malignancy of the tumor is frequently raised, owing to the number and thin walls of the blood vessels. Polymorphonuclear leucocytes are also seen in this specimen, which indicate some degree of infection, which is not strange when we know that the growth hung in the naso-pharynx. The epithelial covering of the tumor is often of the ciliated variety.

With reference to the case in question, the patient was Mr. F., aged 21, who had been afflicted with what was pronounced by his physician nasal catarrh. The diagnosis was made from a statement of the symptoms of the patient, and without examination of the nares or pharynx. The patient was instructed to travel throughout the South and West, with a view of obtaining a cure of his catarrh from climatic influences. He traveled in Texas, Tennessee, Georgia, and in Colorado quite extensively for over three years with no amelioration of the obstructive condition. At the end of this period, after having spent much time and money, he returned to his physician,

who then, for the first time, inspected the nares and naso-pharynx, and the tumor that you see was discovered. He was referred to me, and the operation of removal of the tumor consisted in spraying the parts with adrenalin solution, and then the introduction post-pharyngeally of a wire snare, which very easily engaged the lower third of the tumor. The tumor was very easily removed by slight traction. There was very little hemorrhage following the removal of the tumor. The patient is now breathing freely through the nose, and is practically cured of any disturbance he had from the presence of this tumor.

John Edwin Rhodes,  
Official Reporter.

The Physician's Club of Chicago held its regular meeting at the Sherman House, March 30, 1903. Henry T. Byford presided. The topic for discussion was *The Race Problem in the United States*.

In the absence of Graham H. Harris, Esq., formerly president of the Board of Education, G. Frank Lydston was called upon to open the subject. He stated that the color line as drawn in the United States and especially in the south, is not a theory, but a condition which must be met and settled sooner or later. The issue could not be dodged and the whole question is becoming more and more insistent. Much of the feeling in the south against the Negro has been fostered by northern newspapers either through ignorance of the exact state of affairs, or through bias and purposes political, ambitious, financial, profit and otherwise.

There is no subject of equal importance before the American people today. We speak of the northern conscience in regard to this matter, but the northern conscience is in its last analysis largely the product of the balance between profit and loss. The commercial and financial question has a whole lot to do in connection with the northern view of this race problem as it presents itself in the south. The first great wrong that was committed by the white race was the enslaving of the blacks; the second was the giving them their freedom in the way that it was done. For years slavery kept the black race in a most unwelcome and unwholesome environment; gave them no moral training; kept them as helpless as children; and endeavored in no way to lift them up to the full stature of manhood and citizenship. Then came their emancipation; complete freedom with all its responsibilities, for which they were absolutely unprepared. But even this was not enough, it seems. For the Negro, uneducated, untrained, just escaped from bondage with all its long years of vicious training rather, was given the power to vote, one of the most responsible duties of a citizen. For this great error the Republican party of that day is answerable. How could it have been expected of such a freed man to exercise the right of the ballot intelligently? But that made no difference; votes, mere numerical votes, were what was wanted, and as the Negro looked to the Republican party for his deliverance from slavery, so now it was an easy matter to get him to cast a vote, unintelligently



though it be so far as he himself was concerned, in favor of the Republican candidates. The "carpet-bagger" was much in evidence in those days and his existence was largely the result of this sudden enfranchisement of the ignorant freedman. The carpet-bagger and his influence had much to do in disturbing the harmony—what harmony there was—between the black and white races in the south. The whole question of slavery, its existence, its termination and its ultimate results is most decidedly a national question. But strange to say, the race problem as it now confronts us is regarded by many people in the north and south as a strictly southern problem. This is a mistake. It involves the whole nation, and just as the whole nation at one time permitted slavery, so now the whole nation is concerned in the removal of its unfortunate results. It is only in America and here in the United States that this color line is drawn so sharply. Neither in England nor on the continent is the Negro regarded with such aversion as he is here. Hence there are local causes for this feeling, aside from that of mere color and these are largely of the nature of prejudice.

Much of the trouble with the southern blacks of the present day turns upon their immorality, and yet the whites are largely answerable for the negroes moral conceptions. In slavery the Negro was a mere piece of property, a sort of useful, pet animal, profitable to breed; therefore he was not particularly encouraged to be scrupulously moral, but rather to breed and develop in numbers. Is it any wonder then that he now fails to comprehend the sanctity of marriage and moral restraint. All through slavery the standards of morality were difficult as between the white and black races. Laxity among the latter was winked at and in some quarters even encouraged for purposes of profit. Since the emancipation of the Negro, the relative position of the two standards of morality have shifted somewhat and the colored man is held to a stricter accountability in regard to his mode of life than is the white man. The Negro woman is treated as if she had no soul and men use her for purposes of prostitution who would not think of using the white woman to the same extent. The relationship of the white men and black women in the south is not unknown. Perhaps it is no worse than the same sort of prostitution everywhere, but the curious feature about it is that the same leniency is not extended to the black man for his immoral tendencies as is extended to the white. When the black man commits a crime in the south there are lynchings and other lawless outbursts of passion and bad feeling, but when the white man commits the same sort of a crime, the court of justice takes charge of him, a trial is conducted and the legal punishment is meted out. All of this demonstrates that the same laws of morality, and justice are not instituted for the two races alike. The dominant race acts not upon principle, but upon feeling and prejudice.

The Negro in the south is undoubtedly in a low stage of development. He is ignorant and

almost savage but he has vast possibilities in him as shown by such examples as Booker T. Washington, Stephen Douglas and the gentlemen present at this meeting. It is a great mistake however to take this brilliant example as an average possibility as much as it would be to judge the average Englishman in Queen Elizabeth's day by such men as Shakespeare, Raleigh and Bacon. Between the southern blackman and the examples cited, there is an average which can and will be struck if the race is given a chance and the time.

The speaker frankly confessed that he could see no solution of the race problem, that would ultimately wipe it out altogether but miscegenation. Intermarriage will so amalgamate the race, that the present prejudices will of necessity vanish. The justice of voluntary miscegenation is not open to question. Everyone should have the right to marry whom he pleases. Legally or illegally the two races will thus more or less intermingle. There should be no barriers set up against this intermarrying of the races. In time if this intermingling of the racial blood were permitted there might develop a superior race certainly there would be a most complete and natural solution of the racial problem. Unless some solution of the problem is obtained, there will be the outlook for a most disastrous racial war. The blacks will not be kept down, increasing numerically as they are and developing amongst them here and there men of intelligence and power who will be able to lead them into the conflict for their rights of equality.

The next speaker was C. S. Bacon who presented a paper, an abstract of which is as follows:

#### The Race Problem.

The 12th census shows that the Negroes are increasing in number in this country nearly as fast as the whites. Their birthrate is even higher. There are now about 8,840,000 Negroes including mulattoes in the United States; this being an increase of about 1,350,000 or 18 per cent during the last decade. They will probably continue to constitute about one tenth of the population for years to come.

The morbidity and mortality of the blacks is however considerably greater than that of the whites and seems to be increasing while the white mortality is decreasing. Malaria, yellow fever, consumption and lung diseases are the chief causes of sickness among adults. The infant mortality is very great and probably due in great part to neglect. This large infant mortality is of much importance, for it follows that a larger portion of the Negro population is found in the early age groups and a less number in the older and more valuable members of society.

The mulatto is more sensitive and less resistant to disease than the full blooded Negro.

Amalgamation of the white and black races will probably never occur. Perhaps one tenth of the colored population is now mulatto. By mulatto we mean one who has one half or more white blood. In order that this population of mulattoes be maintained it will be necessary for the mixing of white and black to continue at the rate of 10 per cent, that is one tenth of the colored children born must have one white par-



ent. Much mixing went on under slavery, during the war and for some years after the war. Lately the growing tendency of the Negroes to segregate and the race antipathy will begin to reduce the rate of amalgamation.

The tendency to Negro segregation is a very important deduction from the study of the movements of the Negro population. In the North the number of Negroes is decreasing and they are colonizing in cities and there in limited quarters. They are migrating from the border states. In the South they also congregate in the cities. In the agricultural sections they are found in increased numbers in certain sections which form the great black belt. The continuation of this tendency may result in the formation of Negro reservations similar to the Indian reservations. If the race degenerates and proves unable to hold its own these reservations will be gradually contracted until the Negro will be eliminated like the Indian. If the effort to improve the physical, economical and moral conditions that is now being made by the great and wise teachers of the industrial schools should succeed the Negro reservations will become valuable parts of their respective states and of the nation and will deserve and secure their autonomy.

The means of improving and saving the race are not the suffrage nor an impractical education but rather the industrial education just mentioned. Another valuable help would be the adoption of a thorough system of public health supervision. Especially in the cities such a system that would not only keep them clean, control contagious diseases, provide thorough vaccination, prevent the sale of contaminated food, but also supervise the lives and habits of the people would not only prevent much sickness but have also an important educational influence.

The Rev. R. A. White the next speaker, said he had just spent several months in the South, studying the question. He would merely attempt to give some impressions he gathered. He is convinced that the whole race problem is in its last analysis a mere matter of race prejudice. If this prejudice of the whites against the blacks could by some miracle be gotten rid of, there would be no longer any problem. If the mere personal feeling in the matter could be eliminated, the whole question would soon work out its own solution. Three things seemed to him to stand prominently out as abetting the feeling that exists between the races. For these the white race is responsible. The whites seem to feel especially, (1) social equality, (2) political supremacy of the blacks and (3) their industrial competition. The speaker emphatically wished to be understood as not in the least criticising the southern whites. The probability is that the northern white man would act the same and feel the same as the southern white were he in the latter's place. It was nothing less than a crime to bestow the franchise upon an ignorant race such as the southern blacks were after the war. The government spent millions of dollars to preserve the black man's right to vote, but not a cent to train and educate him how to vote or to exercise his franchise intelligently. The whole question, was one of personal politics and

of course was bound to result, under the conditions existing, in gross errors and wrongs.

The fear of social equality is not altogether unnatural but yet a little calm consideration will show that social equality is hardly possible. In fact the southern Negro does not want or expect social equality as the white man fears it. He does not expect to affiliate with the white man in his social life. All he asks for is the equality he is entitled to as a free American citizen. The fear of political supremacy is also natural as the blacks in some parts so far outnumber the whites. The only offset to this fear, so long as the blacks hold the right to vote, is to educate them and elevate their morals. The white race is largely responsible for the present condition of the blacks in regard to their morals and intelligence therefore they must bear with them until they have regained their normal manhood and the desired intelligence. The industrial competition of the blacks gives rise to a very natural fear as here and there they are amassing wealth and taking quite a prominent place in the commercial and industrial world.

The unfortunate part is however that these various fears are now passing over into the field of education. At first the south favored the education of the blacks; now it fears this educating of them because it favors their rise in the social, political and industrial spheres. The cry in the south now is against the education of the Negro.

In regard to the immorality of the Negro, who taught it to him? The Negro has had but 40 years of freedom and civilization whereas the Anglo Saxon has had 4000 years. The wonder is that the difference between them in regard to morality is not greater than it is. This is not said in criticism of the south, however. The south has a great burden laid upon it and an immense responsibility. Even in spite of the short time and the many handicaps, the Negro has improved and the situation shows signs sufficiently marked to give one hope for the near future. It is wrong to compare the poor Negro with the rich southern gentleman. He should be more just compared with the poor and downcast whites of whom there are enough and to spare in the south. The problem of the so-called "white trash" is almost as serious a problem as that of the Negro. These whites live in back woods, in huts and hovels. They are without schools. Their lives are a barren waste. They are not much above the Negro and yet no one speaks of a problem in regard to them. Therefore it is plainly a question of the color of the skin. Give the Negro half a chance and he will come out all right. The signs are hopeful. He is rapidly amassing wealth. In one place a whole village is owned and run by a wealthy Negro. Property to the amount of \$50,000 and \$75,000 is frequently owned by colored men. In Virginia the black men own one-third of the land. In Alabama the white poll tax amounted to \$8,000 whereas the colored amounted to \$15,000. In Richmond \$135,000 in banking are held by Negroes. The early education of the Negro, as for instance in Latin, Greek, Music, etc., was ridiculous. This worked him harm and now the southern whites are turning against education as a solution of the

race problem. The education that the Negro needs is the education that shows him that work is honorable and teaches him how to work and to do things. Booker T. Washington is doing the grandest work of any one man for the south and his methods will go farther to solve the problem than anything heretofore proposed. Strange to say, however, there is a strong antipathy to Mr. Washington throughout the south. Everywhere the south says to the north "hands off" this is our problem and we will solve it. Such expressions were heard before the war in regard to slavery. No, this is a national question and if the south cannot or will not solve it, the north will go down there and solve it for them.

William A. Pusey spoke next and stated that the biggest problem is to teach the northern white man the point of view of the southern white man. He was acquainted with the south, having lived there a large part of his life. He objected strenuously to the wholesale charge of immorality in the south. Prostitution and the "sowing of wild oats" among the young men is no greater there than everywhere else. The only difference is that in the south the Negro woman offers the readiest means of yielding to this passion. The question of immorality applies as much to the north as to the south and hence is not in any sense a part of the so-called race problem. It is an unwarrantable assumption, a mere attitude of virtue for the north to prate thus about the immorality of the men of the south.

Again, the lynchings for crimes against women in the south are exceedingly rare. Lynchings do occur in the north, though rarely. That is hardly a fair question to discuss as a part of the race problem. It is rather a question of law and order and applies to black and white alike.

Miscegenation as a solution of the problem is merely a doctrinaire assertion. The south however, is not opposed to it, if it is practicable and able to settle the question. The speaker does not believe it will to do so however.

As to the race prejudice, so much spoken of tonight, two things are to be said, first, it is extremely irritating to be surrounded by a vast, idle, inexpressible, ignorant population as the whites in the south are by the blacks. Secondly, it is most annoying to have someone else, some outsider, everlastingly coming in to solve one's own difficulties. The north has exercised a mischievous interference in the south. Instead of northern complacency, there is a superior assumption of virtue. This race problem in the south is no greater than the labor problem in the north. The speaker then argued and illustrated from personal knowledge the childishness, inferiority, and primitive tendencies of the Negro. He shows no initiative in anything. He is a slave and servant at all times. He loves much finery and variety. He steals and does many things that reveal his undeveloped condition. Therefore he is not the equal of the white race. The fear of social equality referred to by Mr. White, does not exist in the south.

The solution of the troublesome side of the problem, so far as the south is concerned is undoubtedly the disfranchisement of the Negro.

Charles E. Bentley presented a paper as follows:

#### The Race Problem in the United States.

The Anglo Saxon has been characterized as the "most arrogant and rapacious, the most exclusive and intolerant in history." And one could add that he is a true lover of a square fight and usually gives the other fellow a fair show in the game. There is evidence of that spirit in this discussion tonight, and the many of like character which are taking place in all parts of the country, where the fellow against whom a fight is made is not to be condemned unheard, but is asked to state his "case in equity."

The Negro race has a growing number of students trained in sociological and ethnic knowledge, who have devoted their lives to the study of the question under dispute, and whose mental alertness and complete training make them the champions to whom we look for our defense. I could wish that one of these experts could assume my part of the responsibility of this evening. However, every thinking, conscious Negro in this country lives closely to these questions, which make towards the present and future happiness of his people, and when the opportunity offers, he must speak with what strength may be given him of this which is of such vital importance.

I will use my few minutes in speaking of one phase of this question, the present most acute symptom of the Negro problem—the disfranchisement of the Negro in certain States of the south.

Now, Mr. Chairman, it is a fundamental principle of good government that a State should do what is best for the largest possible number of its people. The State may take away privileges from certain of its people in order to protect its best interest. Failure of an ignorant group to understand the meaning of the franchise might be just cause for its forfeiture. No educated Negro objects to this. But that the ignorant Negro group should be singled out from other groups of ignorant, is what makes a stench in the nostril of any man who has spelled the first syllable in the meaning of the word democracy. It is unjust and unconstitutional, and can only stand on the ruins of a great republic.

What is the basic cause which is responsible for this feeling against the Negro? The different manifestations of this cause are so varied and often so inconsistent that they are at times confusing, but after the last analysis you will find that the real cause is prejudice—and prejudice can be said to have as its fundamental root the fact that one man has something which the other has not, and is his superior in some respects.

The intelligence of a State finds between itself and an ignorant white group merely a difference in development. When it twins to the ignorant Negro group, it finds in addition to this difference in development a racial difference, out of which grows an **emotional issue**, which is stronger than love of country, stronger than al-



legiance to the very spirit of the government, for which their forefathers fought and died. This emotional issue, which we call race prejudice, is so strong, virulent and apparent that it has been found to be the most effective weapon upon which to rely in any racial emergency. The realization of the potency of this weapon is seen in any political conflict in any southern state, where the votes of white and black are about equal, when the cry of Negro domination is sufficient to cause all the whites to vote one way. Let us repeat. The stability of a democracy depends upon the intelligence of its constituent units. The American Democracy, at the time of the emancipation, found on its hands a large mass of unintelligent units. It sought to make of them worthy units by granting them immediate franchise. Did it succeed? Those who would deprive him of this privilege say No, that the Negro has not qualified himself for this high trust. That is the alleged reason—but it is only a partial one.

In considering this disfranchisement of one group of Americans, we can, without partiality, recount three charges:

1. The alleged charge that the Negro has failed to qualify.

2. The intelligence of certain States seeking to protect themselves by excluding ignorance—ignorance and Negro, in this case, being the same thing.

3. The effort of a machine to control politics.

As to the first, it must be admitted that there is a large number using the franchise unintelligently—just as there are large numbers of unintelligent white voters in all parts of the country. Perhaps it is for the best to restrict the franchise, providing it applies to all alike, regardless of color. We have to-day a growing number of Negroes who are able to use the franchise intelligently. This fact indicates that the Negro has made some advancement in civic worth. The most intense negrophobist must admit that the Negro has advanced along the lines of civil and industrial progress. Now, if you claim that it was a mistake to give him the franchise at the beginning, you must face the question, whether, if he had not started with the franchise, he would have made the same advancement in civic worth, and in intellectual and material advancement that he has made?

The nation, after emancipation, was confronted with a condition which had to be met. The ways and means had to be devised which would secure the protection of the Negro politically and otherwise, and that would give him a basis for advancement. The franchise was given him as a means of securing political and civil rights, this being used as a means to meet a serious and complicated emergency. This condition was the culmination of a long series of causes. A nation, sick from a most terrible struggle, was forced to get rid of the results of slavery, and this could not be done without most painful travail. One hesitates to say so, yet in the light of history one is not entirely unjustified in saying that in a democracy, as the United States that kind of condition could not have been conquered without some attendant corruption. Witness, the Tweed ring the

army scandals and the Credit Mobilier. All—like the reconstruction scandals—the result of the condition in which the nation found itself.

The man of fair and unbiased mind, before he decides that reconstruction was a failure, and that the franchise given to a recently freed people was a mistake, cannot escape a certain duty. To-wit: He must show that the non-granting of the franchise would have caused less corruption in those unsettled days of upheaval. He must show that without the franchise the Negro could have been secured in his political and civil rights. He must show that without the actual possession of the franchise the Negro would have put forth the same effort, and have made the same advancement. The franchise held before him as a something which not he, but his children, would realize would have made a glorious ideal for his aspiring. But not ideals, but the concrete, appeals to ignorant minds. A granted franchise was the concrete. In using it he had made mistakes; he has not attained all that was expected, perhaps, but lacking it, set adrift in uncertain and conflicting streams, with no spar to which to cling, would he have stemmed the current even as far as he has?

As to the effort of the intelligence of certain states to protect themselves against ignorance—which takes the form of that worn-out shibboleth, *social equality*, a little clear-headed, disinterested thought will show on what a frail foundation it rests. Search up to the very dawn of history, and you will find no instance where ignorance has dominated intelligence. It is the intelligent minority that has ruled the affairs of men since in Eden that wily minority of one found a way to affect and change the entire lives of a guileless and unthinking majority.

Social equality does not mean social affiliation—let us bear in mind; and it is a lack of clearness in definition which makes a confusion of ideas in this case. Social affiliation is, perhaps, as distasteful to the Negro as to the white man, but social equality he must have, as it is the *sine qua non* of an equality in all the lines of life which make for the fullest development of his manhood. It means an equality of opportunity, lacking which he must be very heavily handicapped in the material as well as spiritual race he must run. (Extract from Dubois).

The strongest cause for the Negro's disfranchisement, to my mind, is the effort of the machine to control politics. The strenuous objection that the south makes to a reduced representation seems to indicate this. In their effort to control, they would destroy the cornerstone of our democracy.

The very essence of a democracy is incorporated in the words of the constitution, which specifically states: "Governments are instituted among men deriving their just powers from the consent of the governed." For any group of men to be governed without any word as to the form or character of that government, without such modification being applied to all alike, becomes a menace to our republican form of government, and makes of the Constitution a worn-out platitude.



As Abraham Lincoln long ago said: "No man is good enough to govern another man without that other's consent."

This prejudice against the Negro is most brutal and unjust, and seems to increase in proportion to the progress which the Negro has made to a higher manhood. Increase in intelligence, development of higher character and a greater strength in things material have had no power to mitigate in the slightest degree this most inhuman discrimination. In the light of this fact, it is but just to demand that the Negro should have the one weapon which could insure him his social and political rights, the only means by which he can prevent the utter destruction of his civic manhood.

"Better all men up than some men down," has been said by one of the most courageous and most just Americans who has ever been placed at the nation's head. Because of his race to close the door of opportunity against any American, in this nation of many races, is in direct violation of that Constitution which he has sworn to uphold, and even those who are not of his political party must honor Theodore Roosevelt for his loyalty to his oath, as well as the broad humanity which guides him to the clear construction of the obligation of that trust.

I can do no better than to close with another sentiment of this man of strong soul:

"When all is said and done, the rule of brotherhood remains as the indispensable prerequisite to success in the kind of national life for which we all strive."

S. Laing Williams, Esq., followed Dr. Bentley, thanking the Club for the privilege of speaking in behalf of the colored man. The problem is a dark one indeed. The educated Negro realizes all but too keenly that there is a race problem. It confronts him on every hand in his daily life work. But it is a problem for all black and white alike. If things were different there would be an easy solution. The American people are fair and have a lively conscience so that the speaker feels no fear but, that the question will be ultimately settled and settled to the advantage of all concerned. We hear the cry of injustice. No matter what the Negro's character and intelligence may be, he is what he is so far as his citizenship goes by virtue of the 13th, 14th and 15th amendment of the constitution. He is a citizen of the United States and of the State in which he dwells. Therefore the Negro has social rights, else the constitution of the United States is not worth the paper it is printed on. The question of social equality is a noted superstition. There is no such thing as social equality, unless both sides agree to it. The Negro when educated becomes a consumer; hence he helps to create a market and therefore is a desirable factor in the nation. He moreover has an inalienable right to an education as a citizen of the United States. He has a right to work. Your very wealth and industrial success has been largely due to the working of the Negro in the cotton fields for the last 200 years. The Negro has become an integral part of the nation and its progress. The south wants the Negroes and is not de-

sirous of getting rid of them. During the slave days, the Negro was as a rule the only mechanic. It was he who builded and made things. When did he learn this if he was such a savage so foolish and childish? If the Negro is left alone and given as fair a chance as the white man is given, he will work out his own solution in the south. There are 10,000,000 of them. They show patience, aptitude and endurance. The early education that was given them was the best for that time. Since the war there have been 30,000 teachers educated and sent among them. Keep the college doors open. The race prejudice is here in the north as well as in the south. The south has only known the Negro as a slave. Give him a chance and he will make the south know him otherwise. It will take time and we will have to have faith in the justice and good sense of the American people.

The question was further discussed by A. W. Williams, John M. Dodson, L. Harrison Mettler, B. McPherson Linnell, Rachel H. Carr and Rosalia M. Ladova.

L. Harrison Mettler,  
Official Reporter.

The Chicago Medical Society met April 1, 1903, with President Wm. A. Evans, in the chair.

F. E. Wynekoop presented a paper on the **Bacteriology of Influenza**. The author demonstrated his methods and the importance of his mode of dealing with influenza. Among other matters showing the ubiquity of the germ and its frequently puzzling character, he cited a series of more than two thousand examinations made for physicians who suspected their patients of being afflicted with diphtheria. Of the two thousand cases, five hundred were demonstrated, by the finding of the germ, to be influenza, and appropriate treatment was then instituted.

#### Nervous Complications of Influenza.

Charles L. Mix, in discussing this phase of the subject, stated that the bulk of the work which has been done upon the nervous manifestations of influenza was accomplished in the whirlwind of investigation which followed the pandemic in 1889 and 1890. The nervous forms of influenza in general may be divided into those which are associated with gastro-intestinal disturbances, those which are associated with respiratory disturbances, and those which are associated with nervous disturbances. To these he would add the mixed forms. Almost no case of influenza is without nervous symptoms. During the prodromata, headache, backache, pains in the extremities, possibly often general pains, insomnia, prostration, are all nervous in origin. During the fastigium invasion of the meninges may occur. There may be various inflammatory forms of cerebro-spinal disease. During convalescence toxic manifestations of the disease once more appear, chiefly the neuritides and neuralgias, not inflammations in the ordinary sense of the word, neuritis here being to some extent a misnomer, but a degeneration, a counterpart of that which follows the toxic influence in arsenical, lead, or alcoholic poisoning.

The speaker considered next the effect of the germs upon the central nervous system.

Diphtheria is associated with as many nervous manifestations and disturbances as influenza. The diphtheritic effect is primarily a toxemia. In addition to being a toxemic disease, influenza is a bacteriemic disease. There is an important difference between diphtheria and influenza, in that diphtheria is chiefly a toxemic disease, while influenza is both a toxemic and bacteriemic disease, consequently the number of complications which may follow after influenza are very much greater than those which follow after diphtheria. For instance, after diphtheria meningitis is practically an impossibility, but it is not at all uncommon after influenza. The effects, then, of the influenza bacillus may be summed up in two words, the toxemic effect and the bacteriemic effect. There should be added still another characteristic of the influenza bacillus, and that is its pyogenic nature. Cases of abscess of the cerebellum have been reported in which neither streptococci nor staphylococci could be found, but merely pure cultures of the influenza bacillus. The peripheral neuritides and psychoses were dwelt upon at length.

#### The Pulmonary Aspect and Complications of Influenza.

In a paper on this subject, Frank S. Johnson stated that the lungs and air passages more than any other single organ are implicated in attacks of this disease. The commonest, also the mildest, form of involvement is catarrhal inflammation, beginning usually as coryza and traveling downward to the trachea and bronchi, involving the pharynx and larynx in varying degrees. The accompanying cough is usually harsh and unproductive; or the sputum is tenacious. More rarely it is abundant and thin; still more rarely it is blood tinged. It may be purulent early in the attack. The catarrhal symptoms are concomitant with the acute general symptoms of initial fever and generalized pain. Physical examination indicates most varied conditions, ranging from bronchitis with infrequent sibilant and coarse bubbling or snapping rales to softer, large and fine rumble, and with the extension of the inflammation into the finer tubes there are heard subcrepitant rales. On percussion areas of diminished resonance, shifting and changing from day to day, are indications of bronchial stenosis or occlusion, or indicate areas of local edema. Those changes may be considered the introductory steps to pneumonia, catarrhal pneumonia, the typical form of pneumonia in influenza, as indicated by fixed areas of dullness and characteristic auscultatory signs. The catarrhal pneumonia may be purely grippal, but is usually the result of mixed grippal and streptococcal infection. Lobar pneumonia is a comparatively infrequent complication of influenza, and is the result of a superadded diplococcal infection. The influenza prepares the way for the secondary infection. The primary influenzal infection exerts a noticeable influence upon the course of the pneumonia. The symptoms of onset are masked by already existing grippal disturbances. The initial chill of lobar pneumonia may be

sufficiently severe to distinguish it from the recurring chills so often observed in influenza. Temperature fluctuation in the course of the complication is more varied. The febrile stage in both varieties usually persists longer than in complicated cases. In croupous pneumonia the crisis may be delayed several days beyond the usual period, or may be marked by temperature phenomena. Resolution also is slower and more often imperfect. Abscess and gangrene are more common. Or the case may drag on to a chronic state, with persistent cough and incomplete restitution of the lung.

Herein lies another danger, namely, tubercular infection, or not infrequently the lighting up of old tubercular foci to acute activity.

Another and very logical complication is pleurisy occurring with pneumonia, and bearing close bacteriological relation to the variety of the lung infection within, viz., Pfeiffer bacillus, streptococcus, staphylococcus and diplococcus. The course is much more serious than is usual with the pleurisies of pneumonia. Absorption is less certain, and transition to the purulent type much more common.

Pleural inflammation does not, however, occur solely as a complication of pneumonia, but may be a primary complicating element, appearing early in the case before other serious chest symptoms are manifest.

One prominent fact is forced upon our observation in nearly all cases of pulmonary complication; it is that the inflammation in its local manifestations is more intractable and prolonged than similar cases not complicating influenza. It is much more prone to end in destruction of tissue, or in suppuration, or to pass into a chronic state, or become the seat of tubercular infection.

The prostrating and enervating effect of influenza is shown in these dangers that follow in its wake. It is a disease to be feared as much—or more—in its sequelae as in its activity.

#### The Diagnosis of Influenza.

B. W. Sippy read a paper on this subject. He said the disease manifestations produced by infection by the influenza bacillus are notoriously variable, hence great care must be exercised in differentiating the disease from an almost countless number of affections that may simulate it. The positive diagnosis of influenza is based upon the demonstration of the influenzal organism. Accurate knowledge of the clinical manifestations of the disease, however, will enable one to make the diagnosis of influenza with a fair degree of certainty, when certain types of the disease are well developed, and especially during the course of an epidemic. A typical influenza begins suddenly with a chill, followed by high fever, lasting from one to several days, associated with loss of appetite, severe headache, aching pains in the back and extremities, together with a disproportionate prostration. In addition to these fairly characteristic general symptoms, largely toxic in nature, manifestations of a more local character are usually present, giving rise to the various types of the disease: The respiratory, the nervous, the gastro-intestinal and the febrile.



The respiratory form is the most common. A coryza or a catarrhal condition of the respiratory tract is not necessary to the diagnosis of influenza. It is estimated that in one-fourth of all cases, symptoms referable to the respiratory tract are entirely absent. The bronchitis of influenza has really no distinguishing features in the majority of cases. Certain minor points are of some value in diagnosis. Bronchitis due to infection by the influenza bacillus is usually diffuse. It is, however, more likely to remain localized in one lobe or part of the bronchial distribution than bronchitis due to other infective agents. The cough may be paroxysmal; the dyspnea is often great, and out of proportion to the physical findings in the lungs. Pfeiffer describes thick, yellowish-green, coin-like balls of sputum as a characteristic peculiarity of influenza.

Influenzal pneumonia may begin with a chill at the onset of an attack of influenza, but it usually develops subsequently during the course of an influenzal bronchitis. True influenzal pneumonia is catarrhal. Croupous influenzal pneumonia is probably always due to secondary infection with organisms like the diplococcus and others that commonly produce a croupous infiltration of the lung. Both the catarrhal and the croupous infiltration are likely to invade different parts of both lungs, and to run the course of an atypical pneumonia. Both forms are usually readily distinguished from the genuine croupous pneumonia, but cannot be differentiated from atypical pneumonia from other mixed infections, except by bacteriology.

Croupous influenzal pneumonia is probably more common than is usually supposed. It cannot be diagnosed without the presence of rusty sputum.

Dr. Sippy drew the following conclusions:

1. The positive diagnosis of influenza is based upon the demonstration of the influenza bacillus in the various secretions and exudates in a given case.

2. The most important aid to the diagnosis of influenza, aside from the bacteriological proof, is the presence of an epidemic of the disease. It is probable that sporadic influenzal infection is not rare.

3. Certain general and local manifestations of the disease have a minor value in diagnosis. Their importance, however, should not be underrated, since these general and local peculiarities cause us to suspect that influenza is present, and thus lead the way to positive bacteriological proof.

### The Treatment of Influenza.

Robert H. Babcock presented this phase of the subject. He said that inasmuch as there is no specific remedy for influenza, physicians are limited to a preventive and symptomatic treatment. The former should include such measures as are calculated to protect friends and attendants from infection as well as those that will guard the patient from complications. To achieve the former end, the patient should be isolated as far as circumstances will permit. If possible, he is to be placed in a room disconnected from those inhabited by the family. Doors leading to the sick-chamber are to be kept closed, and the atmosphere must be kept

well ventilated by having the windows open more or less widely day and night. Protection against draughts and chilling may be accomplished by suitable screens and artificial heat. The sputa and secretions from the throat should be promptly destroyed by a solution of corrosive sublimate of the strength of 1-2000, or some other equally efficient antiseptic. In even apparently mild cases of influenza complications may readily be developed when conditions are adverse or proper treatment is neglected, so that every influenza patient, no matter how mild his attack, should be emphatically warned of the danger of keeping up and should be ordered to bed. The influenza infection is peculiarly depressing to the heart and consequently serious failure of heart power is a positive danger if the sufferer persists in his determination to attend to his usual vocation. The prevention of complications will depend largely upon due attention being paid to the local treatment of the mucous membrane of the naso-pharynx by sprays and inhalations. Under all circumstances the sufferer should be kept in the house, even if he cannot be prevailed upon to take to his bed. The throat is the atrium of infection and therefore in all cases, whether catarrhal manifestations are marked or not, the throat and also the nasal passages ought to receive careful attention by means of sprays and inhalations. Such treatment is not only preventive of complications, but in many cases should form the first object of symptomatic treatment. For the bronchitis some one of the nebulizers on the market will be found serviceable in carrying appropriate antiseptics and expectorants into the trachea and bronchi. If internal expectorant remedies are given, they should be such as will tend to loosen secretions and facilitate expectoration. Inhalations of steam impregnated with an antiseptic and also nebulizations of some oil, as albolene, containing menthol or creosote, often facilitate expectoration and promote expulsion of the secretions with their bacilli. Aside from the strictly catarrhal manifestations, cough is in many cases a symptom calling for special attention. If this is due to irritation of the naso-pharynx or larynx, nothing is more effective than local medication by sprays and inhalations. Menthol in a five per cent. solution in albolene is often soothing, whereas cocaine and morphine seem to the speaker objectionable for several reasons. If the cough is due to bronchial irritation, then nothing is so serviceable as heroin, in doses of one-twelfth or one-sixth, and codeine, in doses of half a grain to an adult. For the purpose of mitigating cough, promoting expectoration and general comfort in cases of bronchitis, the essayist recommended the Priesnitz cross bandage on the chest as it is used in Germany. Pain is so commonly a marked feature of influenza as to demand relief. Phenacetine in combination with quinine has been found so efficient for this purpose as to have become an almost standard remedy. For the often intense pain in the forehead and cheeks cloths wrung out of very hot water often afford great comfort, or a hot water bottle may be laid on the parts over a damp cloth. Fever rarely requires



special treatment, both because it is not sufficiently high and is not so protracted as to prove a serious matter in itself. The gastro-intestinal tract should be given much attention. In the beginning of an influenzal attack it is well to clean out the bowels by the administration of a mercurial and saline, but one should not produce too active catharsis, and he should not repeat cathartics too often. Half a grain or possibly a grain of calomel in divided doses in the evening, followed next morning by a small glass of Rubinat, concentrated Pluto, or other cathartic water, is all that is necessary, after which a daily enema usually suffices for several days, when the previous cathartic may be repeated, if deemed advisable. In the rare gastro-intestinal type, with vomiting and purging, efforts must be made to control, not promote, the evacuations. Then are required large doses of bismuth, oxalata of cerium, tannalbin, and other uniritating astringents, and even morphine hypodermatically or opium by mouth or rectum. The diet should be such as is generally recognized as appropriate to an acute infectious disorder, that is, a light liquid one, of milk, koumyss, matzoon, malted milk, soups, beef tea, made not from the extract, but from Mosquera's beef jelly, meat juice, raw eggs, etc. Alcoholic stimulants in large doses are depressing, but in small amounts may be useful in cases exhibiting marked cardiac depression and may be advantageously combined with the milk and raw eggs. Should other stimulants and tonics be required, there is nothing better than strychnia and nux vomica.

In his closing remarks Dr. Babcock dwelt upon the management of influenzal cases during convalescence. He urged the importance of a thorough disinfection of the house after the inmates have recovered by means of formalin vapors.

W. C. Sanford mentioned a case of lobar pneumonia which came under his observation quite recently, in which, after the crisis, symptoms of influenza developed, and on making a bacteriological examination, the bacillus of influenza was found. He recalled a number of cases of severe bronchitis which were followed by typical influenza. He believes that strychnine, if used early and thoroughly, will obviate much of the nervous and cardiac depression that so frequently occurs in these cases.

B. W. Sippy referred to the work done by Lord, of Boston. Of 100 cases, Lord found 60 in which influenza bacilli were found in large numbers. In about one-half of the 60 cases the influenzal organisms were found in nearly pure cultures. Lord concludes, as the result of his bacteriological investigations, that influenzal bronchitis, apart from epidemic influenza, is rather common, and believes that many cases of so-called chronic bronchitis are of influenzal origin.

Bradycardia is not infrequently present in influenza, varying with the epidemic. Bradycardia may be relative or absolute. In nearly fifty per cent of the cases reported by a German author, bradycardia was an absolute condition. Bradycardia is supposed to be due to the direct

effects of the toxins of the disease upon the vagus center.

The following new members have been admitted. Addresses are always in Chicago unless otherwise stated.

Bates, Morley D., 34 Washington st.  
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 Brandt, F. H., 70 State st.  
 Butts, George B., 59th and State sts.  
 Doederlein, Theodore J., 356 Webster ave.  
 Falker, W. H., 552 E. 63d st.  
 Fuller, Spencer S., Riverside.  
 Fyfe, Richard, 743 W. Adams st.  
 Gregg, H. L., 2102 W. Madison st.  
 Harcourt, L. A., Eureka, Nevada.  
 Horwitz, Alexander P., 4712 S. Ashland ave.  
 Le Count, E. R., 393 S. Marshfield ave.  
 Loew, Alexander, 1000 State st.  
 Lovewell, C. Hubert, 5500 Halsted st.  
 MacKellar, Orville W., 332 E. 63d st.  
 McCullough, John R., 35 Park ave.  
 Payne, Douglas A., 92 State st.  
 Peterson, Wm. A., 100 State st.  
 Ransmeier, Robert E., 2876 Archer ave.  
 Richter, Arthur J., 4650 Grand Blvd.  
 Shaffer, Vesper, 1110 N. Western ave.  
 Steurnagel, G., 941 31st st.  
 Strueh, Carl, 464 Belden ave.  
 Von Colditz, G. Thompson, 269 Lake View ave.  
 Von Rehm, Edmund, 467 W. Chicago ave.  
 Weir, Charles F., 63d and Steward ave.  
 Wheeler, Roy MacW., 128 W. 67th st.  
 Winans, Edward C., 904-103 State st.  
 Windmueller, E., Woodstock.  
 Worthington, M. H., 763 Marshall Field Bldg.  
 Wynekoop, F. E., 411 City Hall.

The Sangamon County Medical Society held its regular monthly meeting in the Supervisor's Room at the Court House, April 13, 1903, at 8:30 o'clock with A. L. Brittin, President, in the chair and twelve members present. The minutes of the March meeting were read and approved. The applications of J. R. Burkhart and Hada M. Burkhart were held over one month for further investigation. The application of C. R. Spicer was favorably balloted upon and he was declared elected to membership in our Society. The application of B. F. Redshaw of Curran was read and referred to the council.

The president was selected as delegate to the House of Delegates and the vice president serving as alternate.

Bills of Edw. F. Hartman Co., \$1.50; Phillips Bros., \$1.50 and Secretary-Treasurer, \$2.00 were read and ordered paid.

O. B. Babcock read a paper on **Billiousness**, although it was not intended to be a scientific paper, the members were highly entertained.

In the place of discussion, Fred S. O'Hara responded with some of his wit and humor.

G. F. Steriker thought the use of Blue Mass and Black Draft were the most efficacious drugs to be used.

R. D. Berry said the liver was the largest and most abused organ in the body; also the most vascular and would perform its duties if properly treated. The improper living of the better class of people, bring about these troubles; they are not good eliminators as are the working classes.

The following application was adopted:

**Application for Membership**

in

**The Sangamon County Medical Society**

Sangamon County Branch of the  
Illinois State Medical Society.

.....190..

I hereby apply for membership in the Sangamon County Medical Society, agreeing to support its constitution and by-laws and the code of ethics of the American Medical Association.

(Signed) .....

P. O. Address .....

Where Graduated .....Date.....

Other Degrees .....

Hospital or College Appointments .....

.....

Member of other societies .....

Date of license to practice in Illinois .....

Date of registration in Sangamon County Clerk's office .....

Name of member of this society for reference .....

N. B.—The annual dues of three dollars (to include also membership in and dues to the Illinois State Medical Society and its monthly journal) must accompany this application.

The Peoria City Medical Society met Tuesday evening, April 7, 1903, at the National Hotel, and was called to order by the 1st Vice President, L. A. McFadden.

Those present were McFadden, Will, Roberts, Sutton, Jeanette Wallace, Hayes, Whitten, Green, Roskoten, Gunn, Hensley, Brobst, E. L. Davis, S. M. Miller, and Collins.

J. W. Hensley reported for the committee on banquet, that the banquet would be held April 21st and each member would receive due notice.

The Secretary read a number of letters received from the members of the Legislature from this district. With one exception, they said they would vote for the bill presented by the Committee on Legislature of the Illinois State Medical Society.

The amendment to the constitution introduced February 17th, was brought up for action, but on motion of H. H. Whitten its consideration was deferred until the next regular meeting.

An excellent paper was presented by G. N. Kreider of Springfield, Ill., Editor of the Illinois Medical Journal, on **Senile Gangrene**. His conclusions were:

1st: Patients subject to senile gangrene are usually intense sufferers and deserve our sympathy and best efforts to relieve them.

2d: Morphine should be used sparingly, if at all.

3d: Massage carefully applied should be used early in suitable cases.

4th: The urine, heart, blood vessels and nervous system should be carefully examined

to determine the cause of the disease and the best means of giving relief.

5th: Age is no bar to operative interference, providing there is no contra-indication in the heart, kidneys and nervous system.

6th: Usually the amputation should not be made in close proximity to the gangrenous spot.

7th: Amputation far distant offers relief from the pain and horrible stench and often results in permanent cure.

8th: Diabetes is not a contra-indication for operation.

9th: Nephritis or valvular heart disease is usually a contra-indication for operation.

The paper was discussed by Roberts, Sutton, Roskoten, Hensley, Gunn, S. M. Miller, McFadden and Will.

J. C. Roberts made a motion that a vote of thanks be presented to Dr. Kreider for his able and interesting paper. Carried.

E. M. Sutton presented a case of **enlargement of the thyroid gland**.

Adjourned.

C. U. Collins,

Official Reporter.

The Adams County Medical Society held its regular monthly and annual meeting April 13, 1903, at the Conservatory of Music. President Gilliland called the meeting to order.

Members present: L. B. Ashton, W. D. Bates, A. H. Byers, C. D. Center, R. J. Christie, Jr., W. E. Gilliland, J. M. Grimes, H. Hart, T. B. Knox, E. B. Montgomery, H. J. Nichols, Jos. Robbins, J. B. Shawgo, Wm. Sigsbee, Sarah Vasen, O. F. Wellenreiter, W. W. Williams, Ernst Zimmerman and J. A. Koch.

The Secretary's annual report: Eleven meetings were held since the last annual meeting. Average attendance was 19. Twenty nine propositions and applications were for membership. Twenty nine were elected. There were eleven regular and four voluntary papers and clinical reports. Dues received and paid to Treasurer, \$147.00. Authorized expense \$52.88. Balance \$94.12.

The Treasurer's annual report: Balance on hand May \$48.54. Received from Secretary during past year \$147.00. Total \$195.54. Paid out on vouchers, \$52.88. Balance on hand, \$142.66.

The following officers were elected for the ensuing year: President, W. W. Williams, Quincy; Vice Presidents, A. D. Bates, Camp Point, Henry Hart, Quincy; Secretary, John A. Koch, Quincy, (Re-elected); Treasurer, L. H. A. Nickerson, Quincy, (Re-elected); Censors, Jos. Robbins, Quincy; C. D. Center, Quincy; R. J. Christie, Jr., Quincy; Delegate for two years, E. B. Montgomery, Quincy; Alternate, W. E. Gilliland, Coatsburg.

Retiring President Gilliland appointed Jos. Robbins and J. M. Grimes to escort President-Elect Williams to the chair. President Williams in a few appropriate remarks thanked the members for the honor extended him and asked hearty co-operation in the society work.

Delegate Montgomery was instructed to vote for the assessment plan at the State Society meeting.

The Secretary was instructed to send to the Treasurer of the Illinois Medical Society \$2.00 for each active member in this Society, as dues for the members in the State Society.

Adjournment.

John A. Koch,  
Official Reporter,  
Secretary.

The Macoupin County Medical Society met April 14, 1903, Carlinville, in the Masonic Reading room with the following members present: E. A. Bleuler, J. S. Collins, L. H. Corr, C. J. C. Fischer, J. M. Barcus, J. P. and J. Palmer Matthews of Carlinville and S. A. Huffman of Chesterfield.

The Treasurer's report showed balance of \$3.30 on hand.

The Board of Censors reported the Essayists Wash and Nifong to continue their papers till next meeting. E. A. Bleuler was added as Essayist. Carlinville is the next place of meeting on the fourth Tuesday in October.

President for ensuing year, L. H. Corr; Vice President, N. A. Crouch; Secretary-Treasurer, J. Palmer Matthews.

The committee on the death of C. T. Dripps of Staunton reported:

Resolved, A page be set apart in the minutes of our Society in memory of our deceased brother and a copy of the resolution be sent for publication in the County papers.

Signed, J. S. Collins, J. P. and J. Palmer Matthews.

A similar report was made on the death of our honored and respected member, John Ash, of Brighton.

A motion was adopted: That the action of the State Medical Society and the American Medical Association in reference to National affiliation is endorsed and if reorganization is effected we will change our constitution and by-laws to comply with its provisions.

Drs. Bleuler and Collins gave a description of their trip to Europe, and their studies at the Vienna Kraukenhaus.

J. Palmer Matthews,  
Official Reporter.

The Physician's Protective Assn. of Jackson County met at Dr. Essick's office, Murphysboro. Called to order by President McAnally.

Dr. Mitchell's amendment to the preamble of the Constitution, presented at last meeting, was first considered. It read as follows: "Motion and second that the constitution and by-laws of this Association be so amended that the name of this Association shall be called the "Jackson County Medical Association," instead of the "Physicians' Protective Association of Jackson Co. Ill." Carried.

Dr. Silvey's amendment was as follows: Art. 5, Sec. 1, to read: Each and every member shall pay in advance \$3.00 annual dues for

county and state societies. This, although universally favored by the members present, was tabled till the next meeting, awaiting the action of the State and American Medical Associations.

The secretary was instructed to telegraph the chairman of the Judiciary Committee urging him to use his influence to get the house to act on the new Medical Practice Act as did the Senate.

J. T. McAnally and H. C. Mitchell were elected as our delegates to the State meeting.

Program consisted of a report of an interesting case of **Gall Bladder Colic with Operation** by W. C. Hill. Discussion by Drs. Mitchell, Essick, McAnally, Knauer, Silvey and Hill.

Next meeting May 21st at Carbondale.

W. C. Hill, Official Reporter.

The Fayette County Medical Society held a very interesting meeting April the 8th. President Moses Haynes made an address on **The Benefit to be Derived from the County Organization** in which he advanced many good reasons why all reputable physicians in the County regardless of schools of practice should be thoroughly organized.

E. W. Brooks read a very interesting paper on **How to Make the Practice of Medicine Pay** which was discussed by all the members present.

L. L. Morey read an instructive paper on **The Urticarias: Their Causes and Treatment** which was discussed by Shelton, Entriken, Brooks and Smith. The secretary was instructed to write the Senator and representatives from this district requesting that they support the bill before the Legislature creating a Board of Medical Examiners.

The following officers were elected for the ensuing year: President, Moses Haynes of Bingham; Vice President, L. L. Morey, of Vandalia; Secretary, A. L. T. Williams, of Vandalia, and Treasurer, F. M. Entriken, of Vandalia. L. L. Morey was selected delegate to the State Society and E. W. Brooks of St. Elmo, alternate.

The next meeting will be July the 8th.

A. L. T. Williams,  
Official Reporter.

The Washington County Medical Association held their second regular meeting for the year in the Court House in Nashville, April 9th. T. L. Granay, the president being absent the meeting was called to order by R. E. Vernor, Vice President. Minutes of the preceding meeting were read, corrected and approved. The Secretary read a letter from T. L. Grany explaining his absence. The name of R. A. Goodner of Nashville, R. B. Jack of Elkhorn and J. L. White of Richview was presented and unanimously elected to become members of The Washington County Medical Association. The Secretary read the action of the executive committee called together by Dr. Harris on Jan. 9, 1903, reported on page 559 of The Illinois Medical Journal, which was discussed, but final action was deferred until the next regular meeting. David Neer of Beacoup



read a very interesting and instructive paper on the physician prescribing patent and proprietary medicines, which was very much appreciated by those present. Dr. Neer was requested by the Association to send the paper to the Editor of the Illinois Medical Journal, which he promised to do after he made some corrections.

J. J. Trout,  
Official Reporter.

The Christian County Medical Society met in regular session Thursday afternoon, April 16, at the City Hall in Taylorville. President J. N. Nelms in the chair with twelve members present.

The minutes of the last meeting were read and approved.

F. E. North gave a report of case of **Pneumonia following measles** which was very interesting.

M. W. Staples reported a case of **Gall Stones** with the diagnosis not correctly made till the patient was on the operating table, with some very good suggestions.

Guy L. Armstrong's application for membership was presented and by unanimous vote he became a member of the Society.

Major W. T. Vanderveer having stated that Taylorville ought to have a Hospital and that he would like to do something very substantial in that way, a committee of three, composed of Drs. Johns, North and Hill were appointed to wait upon the Major and see what he would do, and report at the July meeting.

W. T. Brides,  
Official Reporter.

The Southwestern Section Medical Society of Chicago held the thirtieth regular meeting at the Grace Cafe, Tuesday evening, April 14th. Society was called to order by President Eggert, after the usual lunch, and introduced the speaker of the evening, B. W. Sippy, who gave a very instructive and interesting talk on the subject **Uremia**, going into the history, the etiology, symptoms, diagnosis, differential diagnosis and treatment.

The regular order of business was then gone through.

The program committee announced for the May meeting a paper, on **Lymph Glands of the Neck** by J. P. Webster and Dr. Simpson.

A motion by Dr. Weir, seconded by Dr. McGonagle, that the Society extend a vote of thanks to Dr. Sippy was unanimously carried. The attendance of the evening was twenty-five.

Several names were presented for membership. Society adjourned.

Thos. C. McGonagle, Official Reporter.

The Cass County Medical Society at our annual meeting at Virginia, April 13, 1903, the various offices were filled by the following:

Geo. Bley of Beardstown, president; M. J. Palmer, Beardstown, 1st Vice President; D. A. Gaily, Ashland, 2d Vice President; J. A. Mc-

Gee, Secretary; J. G. Franken, Chandlerville, Treasurer.

All old committees were continued as in the preceding year. Our Society is in a flourishing condition, although owing to bad roads, a part of our members having to drive some distance we have been unable to hold regular meetings. Considerable interest is shown, and we will, I hope, be able to report some papers.

J. M. McGee,  
Official Reporter.

The North Shore Medical Society held its regular monthly meeting at the North Shore Lunch Room, 1880 Evanston ave., Tuesday evening, April 7, 1903. Maximilian Herzog was in the chair. In the absence of the Secretary Ross C. Whitman was elected temporary Secretary. Dr. Herzog read a paper on the **Histo-Pathology and Pathological Chemistry of Diabetes**. The paper was discussed by Drs. Patton, Healy, Chapman, Green and Herzog.

J. P. Houston read a paper on **Some Observations on the Gastro-Intestinal Diseases of Children**. Discussion by Drs. Garvy, Reed, Green and Houston.

The Committee on Constitution and By-Laws reported, and with the addition of a few amendments and substitutions the Constitution of the North Shore Branch of the Chicago Medical Society, as reported by the committee, was adopted. J. H. Hoelscher was elected Councilor from this district. J. P. Houston was elected Committeeman for the south part of this district. It was voted that the selection of the meeting place be left to the Executive Committee. On motion the meeting adjourned.

George Edmund Baxter,  
Official Reporter.

The McLean County Medical Society met in its rooms in the Griesheim Bldg., in Bloomington, April 2, 1903.

J. Whitfield Smith gave a synopsis of his paper on **Trachoma**, which he will read before the State Medical Society.

J. B. Taylor gave a talk on **Some Advances in Eye and Ear Treatment** with a demonstration of a number of the newer devices which aid in this special work. Conspicuous among these was the Akouphone, which is used in the treatment both of the congenitally deaf and the catarrhal deaf.

The plan of affiliating the County Society with the State Society as recommended by the later and the A. M. A. was carried by a big majority. Officers elected for the ensuing year are: President, F. C. Vandervort; Vice President, A. L. Fox; Secretary-Treasurer, A. F. Kaeser; Board of Censors, C. M. Noble, C. E. Chapin, J. H. Finelow; Delegates to the State Society, W. R. Shinn, J. W. Smith.

A. F. Kaeser,  
Official Reporter.

The Pulaski County Medical Society held its annual meeting Tuesday, April 7, 1903, at Mound City. The following officers were elected: J. F.

Hargan, of Mound City, President; W. C. Rife, of Villa Ridge, Vice President; A. W. Farr, of Grand Chain, Secretary and Treasurer; M. L. Winsted, of Wetaug was elected delegate to the State Society.

All the physicians in the county outside of Mound City were present at this meeting and several able papers were read and discussed.

A. W. Farr,

Official Reporter.

The Hamilton County Medical Society, was organized on Wednesday 15th inst., with a membership of fifteen out of the total of twenty-six in the County. The officers are as follows: H. E. Hale, president, Belle Prairie; W. F. Hall, first vice-president, McLeansboro; M. C. Dale, second vice-president, McLeansboro; C. N. Lyon, secretary, McLeansboro.

The Cumberland County Medical Society was organized on the 16th, at Greenup, and the following were elected officers: President, L. A. Fisher, Greenup; Secretary and Treasurer, Dr. Rhoads, Toledo.

#### PROGRAM, TITLES AND ABSTRACTS OF PAPERS FOR THE 53d ANNUAL MEETING OF THE ILLINOIS STATE MEDICAL SOCIETY.

The next meeting of the Illinois Medical Society will be held in Tremont Temple, Dearborn and Lake sts., Chicago, April 29 and 30, and May 1 and 2.

A Committee on Clinics has been appointed, and these gentlemen have arranged a schedule beginning on April 22. Free admission is offered to one or more clinics during every hour of every day, except Sunday. These clinics will cover every branch of medicine. In addition, a full program of clinics has been arranged for each day of the meeting. It has been agreed by the clinicians of Chicago that no clinics will be given during the hours when the Society is in session. During each hour set aside for clinics, the visitors can choose from several opportunities.

The programs of Section work are fully up to standard. To hear and discuss the papers in the Sections will certainly be worth attendance on the meeting.

The program places the work of the Business Section, known as the House of Delegates, in the afternoon, and all members of the Society are invited to attend the meetings of this body. Participation in its deliberations is limited to the duly accredited delegates.

The preliminary meeting which has usually preceded the regular meeting, will not take place this year. This meeting grew out of

the inadequacy of the old method of organization to do any business in a deliberative fashion. It is expected that the House of Delegates will supply this deficiency.

It will be noticed that the general session on Wednesday morning is nominal. This is done to fulfill the technical requirements. Really it is proposed to give over the forenoons to Section work. In the afternoon the members can select a program of clinics, visit the House of Delegates, chat with friends in the parlors, visit the scientific exhibit, or renew acquaintance with our friends with things to show, explain, demonstrate, or sell.

The open parlor we hope will prove an acceptable innovation. The scientific exhibit is also an innovation; we hope that this will prove an attraction. Members who have specimens with which they intend to illustrate papers, are asked to leave them in the exhibit except when in use in connection with their papers. Other members having specimens of interest, are asked to place them in the exhibit.

The commercial exhibits are on the 5th floor. No elevators go beyond this floor. Our members can always spend some portion of their time to advantage, in these exhibits.

At the evening general session, we propose to have some addresses by prominent men of the city, after which we will listen to the President's address, and attend to such other business as belongs to the mass meeting. Placing this meeting in the evening is an innovation that we think will appeal to those who have witnessed the usual struggling character of opening sessions.

Thursday evening is left open so that those in attendance can do as they please or go where they please. The lady physicians of Chicago have planned a reception for the visiting lady physicians, on this evening. Other entertainments, somewhat less formal, will be in order.

The Friday evening program has not yet been decided on. We feel quite certain that there will be no formal banquet. There will probably be some stage entertainment followed by a buffet lunch—probably "smoker" would more nearly describe what we now have in mind than would any other term.

The registration office, hotel and boarding house directory, and post office will be at the old hotel desk in the lobby.

It will be remembered that the building is the old Tremont Hotel. The amphitheatres and clinic rooms are those that have been built

In by Northwestern University for its Dental School. The Clinic Room will seat approximately twelve hundred people. The three amphitheatres are on the same floor (the sixth). They will seat from two hundred to four hundred people each.

The building is very centrally located. Every elevated road passes by the door, and has a station just one block away. Every cable system reaches within two blocks. The out-of-town visitors can come on the cars, street or elevated, right to the hall, and find there a list of hotels and boarding houses. The Sherman House is located just across the street. In case he wishes to get farther away, the suburban hotels such as the Lexington, are reached by adjacent car lines.

On Sunday, special trains will leave Chicago for the New Orleans meeting. These trains will provide some time for visiting New Orleans and the neighboring towns, by those who wish. Those who wish to attend such meetings as that of the American College Association, will be in time for them.

The regular trains leaving here up to Sunday evening, arrive in New Orleans in time for the meeting.

The fare will be one and one-third. Members are reminded that in purchasing tickets, they must take a certificate of purchase from the local agent. This must be indorsed by the railroad agent in the registration office, at the meeting.

#### PROVISIONAL PROGRAM.

Place of Meeting, Tremont Temple, Lake and Dearborn Sts., Chicago. Time: April 29 and 30, and May 1 and 2.

#### Wednesday, April 29—First Day.

8:00 A. M. Registration office, Lobby, first floor, open.

9:30 A. M. General Session called to order in Clinic Room, 6th floor.

9:45 A. M. Adjournment of General Session until 8:00 P. M. Same hall.

10:00 A. M. Section I. called to order, Amphitheatre, 6th floor.

10:00 A. M. Section II. called to order, Amphitheatre 2.

10:00 A. M. Section III. called to order, Amphitheatre 3.

10:00 A. M. Parlors open, 2d floor.

10:00 A. M. Exhibits open, 5th floor.

10:00 A. M. Scientific exhibit open, 5th floor.

1:00 P. M. Adjournment of all Sections.

2:30 P. M. Registration in Lobby.

2:30 P. M. House of Delegates, Clinic Room, 6th floor.

2:30 P. M. Clinics in various Hospitals and Colleges.

2:30 P. M. Parlors open.

Scientific Exhibit open.

Exhibits open.

8:00 P. M. General Session.

Welcoming Speeches.

Address of President Harris.

#### Thursday, April 30—Second Day.

8:00 A. M. Registration in Lobby.

All Exhibits open.

Parlors open.

9:00 A. M. Section I, Regular order, place noted above.

9:00 A. M. Section II, Regular order, place noted above.

9:00 A. M. Section III, Regular order, place noted above. Completion of work of this section.

1:00 P. M. Adjournment of Sections I, II and III.

2:30 P. M. House of Delegates, Clinic Room.

2:30 P. M. Clinics all over town.

2:30 P. M. Parlors open.

Exhibits open.

Scientific Exhibit open.

8:00 P. M. No work.

#### Friday, May 1—Third Day.

8:00 A. M. Registration Office open.

9:30 A. M. Parlors open.

Scientific Exhibit open.

Exhibits open.

10:00 A. M. Section I. Regular order.

10:00 A. M. Section II. Regular order.

1:00 P. M. Adjournment.

2:30 P. M. House of Delegates, Clinic Room.

2:30 P. M. Clinics all over town.

2:30 P. M. Parlors open.

Scientific Exhibit open.

Exhibits open.

8:00 P. M. Entertainment in the Clinic Room.

#### Saturday, May 2—Fourth Day.

8:00 A. M. Registration Office open.

9:30 A. M. Parlors open.

Exhibits open.

Scientific Exhibit open.

10:00 A. M. Section I. Regular order.

10:00 A. M. Section II. Regular order.

1:00 P. M. Adjournment of Sections.

2:30 P. M. Clinics all over town.

2:30 P. M. Parlors open.

Scientific Exhibit open.

Exhibits open.

Adjournment.

Sunday, May 3 and Monday, May 4, leave for New Orleans.



## SECTION ONE.

1. "The Dangers of Exclusive Milk Diet in Nephritis." A. C. Crofton, 100 State st.

## Abstract.

The popular prejudice in favor of an exclusive milk diet in nephritis and the fundamental fallacies of this prejudice; the three indications for dietetic treatment of nephritis: (1) Protection of the secreting epithelium of the kidney; (2) protection of the cardio-vascular apparatus, (3) protection of the general nutrition of the patient. Reasons why an exclusive milk diet meets none of these requirements. The best substitute for an exclusive milk diet, as deducted from modern investigations into the causes of nephritis and the excretion of urinary solids in inflammatory diseases of the kidneys.

2. "The Breast vs. The Bottle in Infant Feeding." Alfred C. Cotton, 1485 Jackson blvd., Chicago.

## Abstract.

Mortality statistics of natural and artificial feeding compared. Relative morbidity attending each method. Human milk compared with that of other mammals. Dangers in the acceptance of even the best known methods of artificial feeding, as satisfactory. The more nearly perfect the food laboratory, the greater the possibility of harm from over-confidence in artificial methods. Infants too frequently denied the breast for trivial and insufficient reasons. In view of our knowledge of the morbidity and mortality of the artificially fed, what right have we needlessly to expose any infant to such chances? Plea for the establishment of a bureau of information and supervision to facilitate the procuring of wet nurses when required.

3. "Cockroaches as Typhoid Infection Carriers." Rosa Engelmann, 100 State st., Chicago.

## Abstract.

(1) Vermin as active intermediary hosts of various infections; (2) history of a house epidemic of typhoid fever; (3) Cockroaches; sewage and water denizens not heretofore classed as typhoid infection carriers; (4) need of examination and cultures from intestinal contents and from feet of cockroaches for pathogenic germs—especially the Eberth bacillus; (5) opportunity the coming summer (after necessarily prolonged rainfall) for such work in the vermin-infested slums of Chicago.

4. "Psychotherapeutics." E. A. Edlen, Moline.

5. "Xanthome (or Brometone), a New Sedative; Its Therapeutic Effects in Relieving the Cough and Headache of Acute Tracheitis and in Relief of Asthma." E. Fletcher Ingals, 34 Washington st., Chicago.

6. "Lacunar Tonsillitis." James Moreau Brown, 34 Washington st., Chicago.

## Abstract.

Explanation of the title, giving special reference to the erroneous term "follicular." Mode of onset, its occurrence after intra-nasal operations, extension, etiology, and contagiousness.

7. "Alimentary Putrefaction." J. W. Hensley, Peoria.

## Abstract.

What are the most potent causes of alimentary putrefaction and the dangers arising from decaying putrid matters in the alimentary tract?

Discuss the principal points along the prima via where the ingesta and secretions are most likely to decompose—without normal digestion, thus becoming putrid, irritating and toxic.

Can the contents of the alimentary canal be rendered aseptic or disinfected so as to modify and control harmful decomposition, thus preventing auto-intoxication due to the absorption of ptomaines emanating from decaying, putrid matters, together with toxins which may come forth from the alimentary bacteria which are so abundant and lively where putrefaction is going on?

A solution of these problems is of far greater consequence than to cut for appendicitis, or dredge the Illinois River for typhoid microbes.

8. "The Distribution of Blood Vessels in the Labyrinth of the Ear, with Exhibition of Preparations and Drawings." George E. Shambaugh, 100 State st., Chicago.

## Abstract.

This subject has been worked out by making a large center of celloidin carts of the pig's ear from preparations in which the blood vessels had been previously injected. Such celloidin carts when cleared in creosote become perfectly transparent, and when viewed with the stereoscopic microscope, present a beautiful picture of the circulation in its entirety. Specimens and drawings will be exhibited.

9. "A Few Cases of Hysteria." H. T. Patrick, 34 Washington st., Chicago.

## Abstract.

A report of cases of hysterical paraplegia, hysterical amblyopia with rigid pupil, hysterical anorexia, hysterical pseudo meningitis and hysterical deaf mutism.

10. "Interstitial Nephritis; Its Diagnosis and Management." Edward F. Wells, 47th and Kenwood ave., Chicago.

11. "Arterio Sclerosis; Its Effect Upon Brain and Kidney." Charles Louis Mix, 3035 Park ave., Chicago.

**Abstract.**

- I. Definition. Limitations of the paper.
- II. Pathology:
  - (a) Arterial changes.
    1. In the brain.
    2. Elsewhere, especially in the kidneys.
  - (b) Remote pathological effects.
    1. In the brain.
    2. In the kidneys.
- III. Symptomatology.
  - (a) Cerebral symptoms.
    1. Hemorrhage.
    2. Thrombosis.
  - (b) Renal symptoms.
    1. Their relation to chronic interstitial nephritis.
    2. Their relation to cerebral hemorrhage.
- IV. Treatment.
  - (a) Of the arteries.
  - (b) Of their effects upon brain.
  - (c) Of their effects upon kidney.
12. "Pneumonia as an etiological Factor in Nervous Diseases." Frank P. Norbury, Jacksonville.
13. "Original Researches Regarding Human Sweat." Julius H. Hoelscher, 34 Washington st., Chicago.

**Abstract.**

Over 100 specimens; practical deductions, acenamid loses its antipyretic effect when used in connection with the hot air bath, etc. Diaphoretics should always be used in connection with the hot air bath; sodium salicylate, pilocarpine and acetanilid apparently less toxic when used in connection with hot air baths, etc.

14. "The Diagnosis and Treatment of Obscure Syphilitic Lesions of the Eye." E. F. Snyder, 103 State st., Chicago.

**Abstract.**

Frequency of blindness due to syphilis; frequency with which syphilis simulates various eye diseases; history of a number of such cases; impossibility of diagnosis of such cases from clinical aspect alone; co-existence of syphilis with other diseases; necessity of careful urinalysis in lesions of the eye even though syphilis is known to be present; value of therapeutic test in all suspicious cases; therapeutic methods.

15. "The Insane Temperament." Sanger Brown, 100 State st., Chicago.

16. "The Therapeutics of Suppurating Ear Diseases in Relation to the Bacteriological Findings." Ralph C. Matheny, Galesburg.

17. "The Presence of Seminal Elements in the Urine; Their Significance and their Importance as a Cause of False Albuminuria." Arthur R. Elliott, 103 State st., Chicago.

**Abstract.**

Frequency and clinical importance; entire lack of literature on the subject; physiologic and pathologic conditions under which semen gains access to the urine; chemical re-actions produced by seminal elements in the urine; microscopic characteristics; relation of cases; differential testing.

18. "The Treatment of Some of the Degenerations of the Cerebrospinal Apparatus, with Particular Reference to Optic Atrophy." Archibald Church, Pullman Building, Chicago.

**Abstract.**

The general feeling is that degenerations taking place in the conducting tracts of the cord, as in locomotor ataxia, and atrophy of the optic nerve, arising from any cause, as well as the changes in the brain and cord that are found in parietic dementia are quite unamenable to treatment. In all of these conditions the tendency to remission is in itself a confusing element in judging the therapeutic value of any line of treatment.

In the case of the optic nerve the ophthalmoscope enables us to actually see changes which are taking place and by appropriate tests, variations, for better or worse can be actively determined and systematically recorded.

A number of cases of optic atrophy associated with a secondary syphilis have been under observation for from two to ten years and are made the basis of an estimate of the value of mercury in controlling these degenerations.

Ophthalmoscopic examinations and perimetric records made in these cases by competent oculists, demonstrate that in some instances degenerations in the optic nerve can be distinctly controlled. Other cases of locomotor ataxia and parietic dementia are adduced, in which the clinical records indicate a similar retarding influence upon the processes of degeneration in brain and cord.

19. "Euphthalmin as a Mydriatic for the General Practitioner." Albert B. Hale, 103 State st., Chicago.

**Abstract.**

The use of the ophthalmoscope is becoming more general in medical diagnosis; need of a drug to dilate the pupil not only to study the condition of the fundus and also to note condition of cornea, iris, and lens. Atropin too powerful and destroys accommodation; Homatropin is of only less strength and is expensive; Cocain good, but dangerous to eye: Euphthalmin scarcely affects accommodation, dilates pupil fully and in a short time; has no dangerous

element about it and its effect passes quickly away. Reports of experiments.

20. "Barrow's Method of Formalin Intravenous Injections." J. H. Stealy, Freeport.

21. "Clinical Observations on Arterio-Sclerosis." Charles A. Elliott, Chicago.

#### Abstract.

Properly considered a disease in itself, i. e., a clinical entity, in which chronic bronchitis, chronic nephritis, and high arterial tension and its consequences i. e., epistaxis, central hemorrhage, vertigo, hypertrophied heart, etc., are manifestations.

Theories as to causation: Toxic; stress and strain.

**A conservative process**, i. e., a physiological compensation to conserve degeneration of arteries, manifested by (1) cardiac hypertrophy; (2) thickening and rigidity of arteries; (3) functional contraction of arteries not sclerosed.

**Pathology.** Varieties, nodular and general; irregular distribution of arterio-sclerosis; cardiac hypertrophy right and left sided; cardio-sclerosis; coronary sclerosis; limit of nutritive possibility of heart muscle.

Association with emphysema; arterio-sclerosis of vessels of lung; rigidity of lung (Brasch's theory); theory of common origin of arterio-sclerosis and emphysema; antecedent malnutrition of pulmonary tissue, with atrophy of alveolar walls and disappearance of blood vessels; connective tissue changes.

**Symptoms.** Summed up in high arterial tension, manifested by vertigo, hypertrophy, and often dilatation of heart, accentuation of second aortic and pulmonic sounds; dyspnoea, cyanosis, oedema, enlarged tender liver, evidences of stasis, enlarged prostate, albuminuria, etc.

**Potential Symptoms**, i. e., cerebral hemorrhage, retinal hemorrhage, epistaxis, hemoptysis.

**Treatment-prophylactic.** Essentially, remedies to relieve high arterial tension—nitrites, iodides, cathartics.

Nitro-glycerin most useful; dilates vessels. Cannot hope to affect organic change, but can the functional contraction of arterioles not sclerotic; always enough of latter to affect blood pressure; relieves heart of large amount of work; unloads heart; allows heart opportunity to regain strength; increases nutritive possibilities of heart muscle; relieves bronchitis; relieves enlarged prostate; especially useful during period of functional high pressure preceding anatomical changes in arteries, due to increased activity of vaso-motor system.

Citation of few cases from South Side Dispensary.

Summary.

22. "The Danger that may Lurk in Blind Eyes." Cassius D. Westcott, 31 Washington st., Chicago.

#### Abstract.

Difference of opinion and practice in regard to retention of single blind eyes. Danger of retaining blind, but apparently quiet eyes destroyed by injury and inflammation. Illustrative cases. Danger from malignant disease in some single blind eyes, where accurate and positive diagnosis is impossible. Illustrative cases. Conclusions.

23. "Tonsillar Hemorrhage Following Operation." Lawrence R. Ryan, Galesburg.

#### Abstract.

The comparative infrequency of alarming hemorrhage from the tonsils following amputation or complete removal, seems to have dulled the senses of the profession (not excluding our best authors), to the possibilities of its dangers. It is an old saying that "the unexpected always happens," and this is as true in medicine as anywhere else. The young physician who has never had a case of post partum hemorrhage, sympathetic ophthalmia, or grave tonsillar hemorrhage, is apt to assume that such are impossible.

In my first twelve or fifteen years of practice I never had a case of alarming hemorrhage from the amputated tonsil, but within the past year, four cases have come to my knowledge—one of my own, and three from other practitioners.

Since such an occurrence is a possibility, how shall we guard against it? And if it occurs how shall we treat it? The condition of the patient must be inquired into. Is he a bleeder? Is the hypertrophied tonsil densely fibrous? Are there malignant growths attached? What influence have general anesthesia, adrenalin, or cocaine in the possibility of hemorrhage? What form of tonsillotomy is the best? Comparative merits of the hot or cold snare and the usual cutting instruments, etc. Report of four cases—two male and two female; the two males hemophilacs, etc. The treatment used to control hemorrhage.

24. "In Which Disease may we Expect Improvement of Hearing." J. Hollinger, 103 Randolph st., Chicago.

#### Abstract.

Improvement in hearing.

Introduction: Comparison of methods for comparing the hearing.

Improvement of hearing in acute diseases.

- (a) Simple inflammation.
- (b) Suppurations from the middle ear.
- (c) Mastoid operations.

Improvement in hearing in chronic diseases.

- (a) Chronic suppurations.
- (b) Residues.
- (c) Operations for cholesteatoma.



Chronic progressive deafness.

Differential diagnosis.

1. Affections of the tubes.
2. Spongifying.

25. "Abdominal Pains in Pleurisy and Pneumonia." James B. Herrick, 103 State st., Chicago.

**Abstract.**

Pain in pleurisy and pneumonia may be referred not only to the affected side of the chest, but to the opposite side of the abdomen. In the latter case abdominal disease, e. g., appendicitis, may be simulated. Importance of recognizing the thoracic organ of the pain, as it may thus prevent surgical interference. Illustrative cases. Anatomical basis for the referred pain found chiefly in the course and distribution of the intercostal nerves. Diagnosis generally easy when once the possibility of thoracic cause for the abdominal pain is thought of, and a careful examination of the chest made.

26. "Tabes and Spurious Tabes." D'Orsay Hecht, 4304 Grand blvd., Chicago.

**Abstract.**

1. By way of introduction. (a) Consideration of the term spurious, as here applied; (b) The term pseudo-tabes, a misnomer.

2. Citation of cases with differential considerations.

3. Symptoms, subjective and objective, of genuine tabes in the order of their importance and frequency.

4. Brief therapeutic suggestions.

27. "Unclean Milk; Bovine Tuberculosis and the Tuberculin Test; Their Relation to the Public Health." E. R. Larned, Chicago.

28. "Retinal Hemorrhage in Relation to Degenerations of the Circulatory Apparatus." T. A. Woodruff, 103 Adams st., Chicago.

29. "Pulmonary Tuberculosis and its Home Treatment." James L. Lowrie, Lincoln.

**Abstract not in.**

30. "Some Advances in Eye and Ear Treatment." J. B. Taylor, Bloomington.

31. "A Report of Ten Post Mortems, the Causes of Death Being Lesions of the Abdominal Viscera." Paul L. Markley, Rockford.

32. "The Metric System." John A. Koch, Quincy.

33. "Some Unusual Cases of Chorea." L. Harrison Mettler, Chicago.

**Abstract.**

A report of a few peculiar cases of chorea. Advance of the idea that chorea is a symptom and not a disease, that its etiology is not so obscure as it appears to be, that it has some remarkable frequently overlooked features in its symptomatology and that its treatment is varied, and deserving of more careful study.

34. "Intestinal Antiseptics in Typhoid Fever." N. S. Davis, Jr.

35. "Splenic Anaemia and Anaemia Infantum Pseudoleukaemica." Maximilian Herzog, Chicago.

36. "The Secondary Results of Cardiac Disease; A Case Unique." John A. Robson, Chicago.

**Abstract.**

Discussion of the various valvular lesions and their pathological sequences, myocarditis and the secondary symptoms. A case of mitral insufficiency with ruptured compensation, dropsy, and proliferative inflammation of the skin, with return of compensation and disappearance of the secondary symptoms. The entire circle of invalidism lasted two years.

**SECTION TWO.**

- W. E. Schroeder, Chairman.....Chicago  
J. B. DeLee, Secretary.....Chicago

**Surgery and the Surgical Specialties.**

**Address:**

**"The Renaissance"**

J. L. Wiggins, East St. Louis.

1. "The General Practitioner and his Relation to Early Surgical Operations." E. B. Montgomery, Quincy.

**Abstract.**

The author calls attention to the fact that the internists are too often apt to be influenced by the lay opinion that surgical operations are only to be done as a last resort, and unconsciously lend themselves to delay in a large class of cases that should have surgical intervention early in their course. He contends that the unfavorable results which are shown to follow in too large a percentage of cases of carcinoma of breast and uterus are due to late operation. Appreciating this, the general practitioner should encourage among his patrons immediate consultation of the physician concerning every trouble with the breast in woman, however, insignificant, or any irregular hemorrhage occurring after the age of 40 years, and if there is the slightest question concerning

the presence of malignant disease should associate a surgeon with him in the case. In the author's opinion the same rule should obtain in typhoid fever with any evidence of perforation, in appendicitis, in cholecystitis with enlargement of the gall-bladder, and in enlargement of the prostate gland after the catheter life has begun. In pleuritic effusions lasting over two weeks whether purulent or not, and in hypertrophic cirrhosis of the liver the early presence of the surgeon is advocated. In support of these opinions facts and cases are adduced.

2. "Spinal Injuries." E. Mammen, Bloomington.

**Abstract.**

An array of perplexing problems. Organs involved. Purpose of the paper. The policy of non-interference. Cases. Laminectomy. Principles of treatment.

3. "The Traction Injury of Arteries." S. M. Wylie, Paxton.

**Abstract.**

Normal nutrition and vascularization of the extremities depend upon an unobstructed flow of normal blood.

Stagnation, partial or complete favors the formation of fibrinous clots.

Traction injuries of arteries by disturbing the normal relation and function of the various coats favors thrombus formation in two ways: (1) The ruptured walls of the interna curling up in the lumen of the vessel acts as an obstructant to the current; and, (2) the loss of contractile power from the overstretched or torn muscular fibres favors stagnation and arrest of the flow.

Both are factors in the function of occlusion thrombi causing complete arrest of circulation beyond and subsequent death of the part. This is a surgical accident often overlooked at the time of the first dressing of an injured extremity and when subsequent gangrene ensues as often does is attributed to faulty methods of applying the dressings.

4. "Modern Surgery of Congenital Cleft Palate." S. R. Hopkins, Springfield.

**Abstract.**

History and evolution of the operation.

Description of uranoplastic operation in infancy and its advantages over later operations, with statistics of different operators.

Description of staphylorrhaphy in later life.

Remarks on the power of speech following operations.

Recommendation of a change from the usual modus operandi of closing continuous clefts in children over six months of age, with a report of two cases illustrating the proposed method.

5. "Insanity following Surgical Operations." W. H. Maley, Galesburg.

**Abstract.**

- I. Is it possible for an operation of itself to cause insanity?
- II. The Mental and Physical condition of patient at time of operation.
- III. What cases of operation are most liable to be followed by insanity.
- IV. The effects of anaesthetic, drugs and dressings.
- V. What precautions may be taken to avoid so untoward a result.

6. "A Singular Dislocation of the Metacarpophalangeal Joint, Irreducible under Anesthesia." Homer M. Thomas, Chicago.

**Abstract.**

Relative frequency of this injury:

Anatomy.

History of case.

X-Ray.

Operation.

Presentation of patient.

7. "Successful Removal of a Cystic Fibromyoma of the Uterus, weighing Eighty-seven pounds." J. Clarence Webster, Chicago.

**Abstract.**

Woman, married. Age 41. Tumor of ten years duration.

Measurements: Greatest girth of abdomen, 5 feet. Lowermost portion of pendulous abdomen 11 inches below level of anterior superior iliac spines.

Operation, Dec. 16, 1902. Abdomen opened after Schleich infiltration of skin. Separation of adhesive and ligation of vessels carried out during one hour without any general anesthetic. During another hour and half only ounces vi chloroform used. Panhysterectomy performed. Normal recovery.

8. "Continued Development of the Fetus after Rupture of the Membranes and Prolapse of the Cord." H. W. Chapman, White Hall.

**Abstract.**

Patient nullipara, married. Last catamenia, March 25, 1879. Health excellent until July 5th following, when she was taken with a severe dysentery.

July 7th, rupture of membranes, escape of large quantity of amniotic fluid with a little blood. August 14th prolapse of pulsating cord. August 15th, delivered of a foetus of not less than four months development. Quickening had not taken place, but the cord continued to pulsate several minutes after expulsion of foetus.

9. "The Indications for the Tampon in Post Partum Hemorrhage." C. S. Bacon, Chicago.

10. "Operative Dysmenorrhea." G. Kollischer, Chicago.

**Abstract.**

- (a) Definition of the term.
- (b) Etiology.
- (c) Different methods of treatments; results and criticism of both.
- (d) The author's method.
- (e) Report of results.

11. "A Simple Method of Appendectomy." Emil Ries, Chicago.

**Abstract.**

The old methods of stump-formation, their dangers or inconveniences. Methods without stump. A simple method of doing away with the stump. Clinical and experimental evidence.

12. "The Treatment and the Causes of Death in Placenta Previa." P. M. Burke, La Salle.

**Abstract.**

The point which I wish to make is that cause of death in Placenta Previa is extensive rupture of the womb and not hemorrhage due to mere separation of the placenta in the act of turning as is popularly believed. Out of 9 cases on all of which I turned, there were four extensive ruptures, three of which died and one recovered by immediately repairing the injury. Cause of death applies to mother as the cause of death of child is self-evident. The only deaths were in the ruptured cases unrepaired. The lack of knowledge is due to small individual experience consequent on the infrequency of such cases. In numerous cases of turning in about a thousand cases of obstetrics, I never had a rupture except in placenta previa. The occurrence of rupture in these cases is not a coincidence, but due to the friable, brittle condition of the lower segment of the uterus.

The treatment is surgical action, prompt, heroic and skillful repair of the rupture.

13. "Ovarian Dysmenorrhea, its Treatment by a New Method of Operating." Norman Kerr, Chicago.

**Abstract.**

The frequency of dysmenorrhoea in general and its interest to the medical profession. The unsatisfactory condition of the pathology of ovarian dysmenorrhoea, and its denial by some of the profession. The difficulty of carrying out an efficient treatment in those females who are not in comfortable circumstances financially. The unsatisfactory result of the treatment heretofore in vogue. The indications for the operation and its advantages in avoiding the sacrifice of important organs to the human economy.

13. a. "The Treatment of Puerperal Infection." T. J. Watkins, Chicago.

14. "Pelvic Abscess." J. A. Baughman, Neoga.

**Abstract.**

Great frequency in women; causes of infection; Route of infection; Structures involved; the kind of micro-organisms; signs and symptoms; digital examination the most important; Treatment, expectant and surgical.

15. "The Curette in Puerperal and Non-puerperal Cases." W. P. Davidson, Sullivan.

**Abstract.**

- (a) Definition.
- (b) Technique.
- (c) Etiology.
- (d) Diagnosis.
- (e) Occurrence of puerperal fever after confinement and curette used.
- (f) Non-puerperal cases and results.

15. a. "Practical Comments on the diagnosis and Treatment of Pelvic Suppuration in Women." F. Henrotin, Chicago.

15. b. "Tubercular Peritonitis." J. B. Murphy, Chicago.

16. "Tuberculosis of the Vestibule of the Female Genitals." J. H. Stealy, Freeport.

**Abstract.**

A brief review of cases in literature; the rarity of the lesion; the possible cause of the unfavorable course taken by the disease in this region; the difficulties attending the determination, whether the lesion be primary or secondary; its bearing on prognosis. Tuberculin the only accurate method. Review of a case.

17. "Radio-Therapy, with Report of Some Cases." Chas. D. Center, Quincy.

**Abstract.**

- I. Object of paper to add to clinical findings in x-ray therapy.
- II. While in no way condemning radio-therapy the author believes too much is claimed for this new method.
- III. Divisions of cases as follows:
  - (a) Those in which a cure may be expected.
  - (b) Those where no cure may be hoped for, but where temporary improvement may be secured with considerable retardation of usual course of disease.
  - (c) Those made worse by the rays.
- IV. Report of 9 cases.



18. "Clinical Report of Two Tumors Benefited by the X-Ray." W. J. Eddy, Shelbyville.

**Abstract.**

Mr. A. 27 years. A German. Injury to Tibia, six months after a hard growth appeared. Two years later growth extended over central half of leg and partial destruction of bone. Mass large and hard and very painful at times. Amputation refused. Five weeks treatment with X-Ray, severe burning, violent inflammation, rapid softening, evacuation of 1½ pts. clear yellow serum. Opening and cleaning out of bone, packing and rapid healing, with a weak but useful leg.

Mr. B. Age 45. American. Growth in Axilla that rapidly enlarged and involved the pectoral muscles in three months, no inflammation, sharp pain. Infiltrated all tissues of the axilla and anterior part of the shoulder and showed as large as a man's fist and growing rapidly, firm and hard and soon became immovable. Operation not justifiable as it would involve shoulder and arm. Under X-Ray shrank to a small nodule which discharge a little sero purulent matter and gradually disappeared, leaving function of arm only slightly impaired.

19. "Vibratory Massage in Diseases of the Prostate Gland." L. E. Schmidt, Chicago.

20. "Indications and Limitations and Technic of Prostatectomy." G. F. Lydston, Chicago.

21. "Pemphigus." E. A. Fischkin, Chicago.

**Abstract.**

Definition of the term. The different clinical varieties of the disease. Their pathological sinification. Dermatitis herpetiformis (Duhring) and its close relation to Pemphigus. Report of cases.

23. Title Unannounced. Jos. B. Bacon, Macomb.

24. "The Treatment of Injuries of the Eye." Henry Gradle, Chicago.

**Abstract.**

Distinction between mechanical consequence of eye-injuries and infection. Foreign bodies. Surgical treatment of wounds of the eye. Removal of foreign bodies. Conservative treatment of traumatic infection. Danger of Sympathetic involvement of second eye. Rules for enucleation.

25. "Accident of the Antrum, with Special Reference to a Peculiar Case." E. V. D. Morris, Galesburg.

26. "The Surgical Treatment of Trachoma, with Report of Cases and Demonstration of Method." J. Whitfield Smith, Bloomington.

**Abstract.**

1. What constitutes the cure of trachoma?
2. The object to be attained by surgical procedure.
3. The advantage to be gained by the use of trachoma forceps.
4. A report of six cases, illustrating the operations at different stages of the disease.
5. Demonstration of method employed.

27. "The Treatment of Peri-tonsillar Abscess." Norval H. Pierce, Chicago.

28. "The Management of Crossed Eyes in Children." Willis O. Nance, Chicago.

**Abstract.**

Etiology of strabismus.

Clinical history.

"Early treatment, rational treatment."

Non-operative treatment of very greatest significance.

Atropin, glasses, occlusion pad, stereoscope, bar-reading.

Surgical treatment indicated in only a minority of instances.

29. "Dislocation of the Astragalus; Its Surgical Treatment." J. F. Percy, Galesburg.

30. "Hypertrophic Rhinitis." Charles M. Robertson, Chicago.

31. "Strangulated Hernia: A case which required the resection of seven inches of gut, exsection of the appendix, right tube and ovary and the evacuation of a large abscess." Carl E. Black, Jacksonville.

33. "Report of a Case of Gall Stone Simulating Benign Pyloric Stenosis." J. E. Allaben, Rockford.

34. "Normal Salt Solution in Surgery." F. E. Wallace, Monmouth.

**Abstract.**

Its restricted use among physicians.

Its numerous uses.

Its physiological effect.

Its administration.

Large quantities not necessary.

On account of cheapness do not think worthless.

Case reports.

Conclusions.

## SECTION THREE.

W. K. Newcomb, Chairman.....Champaign  
 W. C. Bowers, Secretary.....Decatur

Address—"Food" by J. A. Wesener, Chicago.

## Abstract.

Definition.  
 Digestion.  
 Assimilation and caloric value.  
 Flavors.  
 Adulteration.  
 Diet for all classes, and adapted to climate.  
 What role does food play on the tempera-  
 ment of the individual?

1. "Some Observations on Iodophilia," Adolph  
 Gehrman, Chicago. (No synopsis.)

2. "The Examination and Commitment of the  
 Insane to Public and Private Hospitals,  
 from a Medical Standpoint," E. L. Crouch,  
 Jacksonville. (Discussion opened by  
 Frank P. Norbury, Jacksonville.)

3. "The Diplococcus of Scarlatinae," W. J.  
 Class, Chicago. (Discussion opened by  
 W. K. Jaques, Chicago.)

## Abstract.

In this paper I will call attention to its diag-  
 nostic importance especially in cases where the  
 rash is atypical. I will also explain some of  
 the difficulties which may be encountered in  
 recognizing the germ and how they may be  
 avoided.

4. "A Sociological View of Criminal Abortion,"  
 W. J. Fernald, Frankfort, Ind., non-resident  
 member. (Discussion opened by E. A.  
 Morgan.)

## Abstract.

The synopsis of the paper runs as follows:  
 It is pardonable to discuss this question of  
 sociology in this Society because the question  
 often presents itself to every physician in re-  
 quests for the performance of this operation.

Since Society must propagate itself or per-  
 ish, the constitution of the universe makes  
 sexual intercourse of prime importance; and  
 has set a price on its indulgence which no mat-  
 ter how man may try to avoid its payment, he  
 must pay. The price of legitimate intercourse  
 is the burden of a family. The price of illegiti-  
 mate intercourse by either husband or wife  
 where the other avoids intercourse because no  
 family is desired, is either disease or a broken  
 home or both. Illegitimate intercourse among  
 the unmarried brings disease, social ruin or  
 homeless children; while no effort made by  
 those indulging in intercourse to prevent con-  
 ception, can be certain to prevent it for any

extended period without producing impotence in  
 the male, sterility in the female, or both.

Looked at from every point of view, nature  
 has so arranged the safe guards of this, man's  
 greatest passion, that its violation in any degree  
 produces a measure of death in the individual,  
 the family or the state in precise ratio as that  
 violation has been successful. No higher price  
 is demanded for any gratification than for this;  
 for no gratification is the price more rigidly  
 exacted; and the price paid for indulgence in  
 any way to avoid responsibility is death to the  
 individual, the family and the state, none the  
 less certain because it is delayed.

It is our business as physicians to realize  
 the fact and instruct those over whom we have  
 influence. For no one can say with such hope  
 of helping those tempted as we.

5. "The Legal Status of the Doctor," H. C.  
 Jones, Decatur. (Discussion opened by  
 Wm. M. Harsha, Chicago.)

## Abstract.

Though the physician is, as a rule, a well  
 informed man, it is a fact that he is lamentably  
 deficient in a knowledge of the law in its ap-  
 plication to his rights and responsibilities.  
 \* \* \* not to be expected that a physician  
 should be his own lawyer any more than a pa-  
 tient should be his own doctor, yet a little more  
 knowledge on these points might save much  
 litigation and trouble. \* \* \* \* \*

The right to practice medicine is not limited  
 or abridged under the common law, which  
 governs in the absence of special enactments,  
 but most of the states have passed laws govern-  
 ing this privilege. \* \* \* \*

It is well for a physician to be sure he has  
 complied with the requirements of the law as  
 otherwise he cannot collect any compensation  
 for his services. To physicians called into  
 neighboring states it is well to know and avoid  
 infringement of their regulations. \* \* \* \*  
 In twenty-four states provision is made for  
 meeting resident physicians in consultation. \*

The law which confers on boards power to  
 grant licenses also gives power to revoke the  
 same for the following causes: \* \* \*

Contracts are either express or implied. If  
 express, they may be written or verbal. All  
 are equally binding, though the stipulations in  
 a written contract are obviously more readily  
 susceptible of proof.

Whenever a doctor undertakes the treatment  
 of a case, certain implied contracts arise de-  
 pending on the relation of the parties. \* \* \*

He binds himself that he is possessed of  
 "ordinary skill" and experience, and that he  
 will "exercise the same" according to his best  
 judgment, and after "approved methods," \* \*  
 \* \* patient conversely has certain obliga-  
 tions as well as rights. \* \* \* \*

Then third parties, by which is meant in-  
 terested parties other than the patient, have  
 certain rights and liabilities. \* \* \* \*

"The amount of compensation a doctor shall be allowed is a matter of fact and not of law."  
\* \* \* "That no benefit was obtained is not a bar to recovery." \* \* \*

In certain states, notably New York and Maine, a judgment obtained for services is a perfect bar to recovery for mal-practice in the same case. In Wisconsin and Iowa a contrary view has been upheld by the courts. Where the former decision is upheld we are encouraged to follow the amended golden rule, which may be paraphrased thus: Do unto the other fellow what he intends to do to you, but do it first.

6. "Bacteriological Examinations of the Blood, from a Clinical Standpoint," L. Hektoen, Chicago. (Discussion opened by James B. Herrick, Chicago.)

#### Abstract.

Synopsis: "Discussions of the technic; summary of the most important results of systematic bacteriological examinations of the blood recorded in the literature; summary of personal work; the scientific and practical value of the method in pneumonia, typhoid fever, in cases of sepsis, etc."

7. "Educational Opportunities and Needs of our Civil Courts, from a Medical Standpoint," O. B. Will, Peoria. (Discussion opened by Harold N. Moyer, Chicago.)

#### Abstract.

The object of this paper is to draw the attention of the medical profession generally to the growing importance of their relation to the civil tribunals of the commonwealth, both in respect to their mutual value to each other and the educational value of their combined influence to the general public. It is argued that at the present time even the technical requirements are such as to demand greater care and attention on the part of medical men than ever before, and that they should, consequently make a greater effort, through preliminary instruction and constant study, to meet these new and ever increasing demands upon them. It is maintained that the progress of medical science and art, as well as the changing demands of civilized life, is continually complicating rather than simplifying the judicial requirements, and hence the need of greater preparation to meet the issues, and keener recognition of their importance.

The point is made that the courts have virtually become arenas for scientific debate, in which the medical and legal professions are often engaged in striving for the mastery, and consequently offer in themselves educational opportunities of no mean scope and degree. In fact this applies not only to the two professions mentioned, but to the general public, who are always interested in whatever of the kind comes up for consideration and adjudication. No other field offers so good a chance for the profession of medicine to exhibit its influence, power and worthiness before the public, and it should take advantage of it in attempt-

ing to secure that consideration in all the demands of life to which it considers its learning and dignity entitled. Attention to this phase of professional involvement should be considered as a valuable opportunity in the scheme of educating the public to that appreciation of professional standing for which we are so constantly contending.

To the above end the author suggests the advisability of the section having consideration of these matters making a routine practice of securing a synopsis of the leading points at issue in the several judicial tribunals during the year, where they involve points of disputation in medicine or surgery, and have them presented for discussion at the succeeding annual meeting of the State Society. It seems to him that nothing could be of greater general value and interest than such a presentation, together with the judgments rendered, and the reasons therefore. Such a course would be of great practical value, and would awaken a lively sense of our responsibility. By way of illustration the author cites a number of actual occurrences during the year, in which medical men were put to a severer test than they ever are in their professional organizations, and draws therefrom the conclusion that it might be well to adopt some such strenuous methods in sifting the wheat from the chaff and getting the best results in medical Society discussions.

8. "Sewage Disposal for Inland Towns." Prof. A. N. Talbott, Champaign University. (Discussion to be opened by C. B. Johnson, Champaign.)

#### Abstract.

Growth of population, conveniences, ideals, and sanitary requirements in inland towns. The purposes of sewage purification and their relation to economy in the construction and operation of purification plants. A brief discussion of the processes by intermittent downward filtration, septic tank, roughing beds, contact beds, continuous filters and rapid filtration and their results. Purification in streams. The operation, supervision and maintenance of plants. Bacterial and chemical results. Comparison of processes, and conditions favorable to selection or operation of the various processes. Duty of the medical profession in raising standards in this line of sanitation.

### Marriages, Deaths and Changes of Address.

#### Marriages.

- Herman D. Peterson, M. D., to Miss Marie Freeman, Chicago, April 20, 1903.  
Samuel C. Plummer, M. D., Chicago, to Miss Middleton, Davenport, Ia., March 18, 1903.  
Wm. A. Campbell, M. D., to Miss Jeannette E. Holsted, Chicago, April 9, 1903.



T. E. McMurtry, M. D., to Miss Grace Polglase, Chicago, April 16, 1903.  
 Dan'l W. Rogers, M. D., to Miss Helen S. Wainwright, Chicago, April 16, 1903.

#### Deaths.

Blaisdell, Warren O., Macomb, March 18, aged 48.  
 Collins, Almer M., Shelbyville, March 10, aged 58.  
 Craig, Jas. D., Chicago, April 13, aged 70.  
 Donkle, Alfred D. F., Chicago, March 13, aged 25.  
 Fox, Julius C., Keyport, March 12, aged 65.  
 Fink, I. W., Hillsboro, April 16, 1903, aged 76.  
 Marshall, Hugh, Monmouth, April 10, aged 77.  
 Martin, Hans. M., Newark, March 17, aged 34.  
 Stuve, Bernard, Springfield, April 11, aged 73.  
 Tuthill, Danl. H. S., Chicago, April 18, aged 43.

#### Changes of Address.

##### Changes To and From Chicago.

Hunt, E. S., to Rockford.

##### Changes in Chicago.

Stubbs, F. G., 4256 Grand Blvd., to 3203 S. Park ave.  
 Wolf, H. P., 4257 Grand Blvd., to 6509 Minerva ave.  
 Montgomery, L. H., 100 State st., to 92 State st.  
 Boot, G. W., 1945 Maple ave., to 1945 Maple ave., Evanston, Ill.  
 Pleth, Valdemar, 750 W. North ave., to 1002 92 State st.  
 Tice, Frederick, to 1496 West Madison st.

##### Changes To and From Illinois.

Freas, F. L., Worthing, S. Dak., to Nulledgeville.  
 Stewart, Chas., St. Louis, Mo. to Belleville.

##### Changes in Illinois.

Holke, T. J., Tallula to Bluff Springs.  
 Patchen, C. C., Chandler, Okla. to Havana.  
 Trinkhaus, J. L., Peoria to Elkhart.

### New Incorporations.

New incorporations were authorized by the secretary of state at Springfield, as follows:

Dinet & Delfosse Pharmacal company, Chicago; manufacturing drugs, medicines, and chemicals; incorporators, Henry G. Dinet, Joseph T. Delfosse, Joseph H. Mulke; capital, \$100,000.

Brainard Polyclinic, Chicago; capital, \$10,000; educational; incorporators, Bayard Holmes, Hugo Oldenberg, Benjamin Levering.

Goat Lymph Sanitarium association, Chicago; capital increased from \$5,000 to \$25,000.

McCormack Bros. Homeopathic pharmacy, Chicago; capital, \$10,000; manufacturing and dealing in drugs, chemicals, and druggists' sundries; incorporators, C. F. Schaefer, Sigmond Goldstein, Alfred F. Tompkins.

H. W. Baskette Medical company, Chicago; capital, \$10,000; dealing in drugs and medi-

cines; incorporators, Edward J. Sandberg, John C. Wilson, Frank P. Reynolds.

Bartlett Cure Company, Monmouth; capital, \$24,000; manufacturer and sale of medicines; incorporators, Daniel C. Bartlet, Charles S. Painter, Charles Tobey.

Finsen Light Institute of America, Chicago; capital, \$50,000; furnish treatment with the Finsen system of light cure; incorporators, Benson Wright, Frank F. Douglas, M. B. Cearon.

#### Dr. Andrews Birthday This Week.

Edmund Andrews, M. D., LL. D., founder of Chicago Academy of Natural Sciences, and one of the leading surgeons of the west.

The best habit Dr. Andrews has acquired in his 79 years, he says, is "sticking to my friends."

"The crowning happiness of a ripe age is to have a good family. Pleasure in age is different from that of energetic exertion in middle life, and one, perhaps, is equal to the other."

Dr. Andrews' recipe for attaining a good old age: "Proper care to avoid diseases and accidents will do more than any other one thing to promote longevity. Few people die of old age under 85. We should avoid preventable things as far as we can, take chances with the rest, and not fret.

"My dear friend, the late Dr. Hosmer Johnson had delicate lungs and through life was expected to die of tuberculosis. However, he was careful of himself and survived a number of attacks of pneumonia. When 60 years of age he was called out on a cold night and took pneumonia, and this time could not resist it. If it had not been for the accident of having been called out that bitter night he might have lived ten years longer."

What most interests Dr. Andrews: "The progress of the human race and the magnificence of nature. I have always been enthusiastic over the magnificence of nature, particularly the splendor and sublimity of natural scenery and the beauty existing in all living natural objects. My greatest recreation is to get away from city life to the lakes, woods, and mountains and spend the time in camp.

"I have always tried not to have hobbies. The study of the sciences, especially surgery, comes as near to my hobby as anything."

Dr. Andrews is an enthusiastic surgeon: "The essentials for a good surgeon are a naturally mechanical head, honesty, and hard study. Surgery appeals to the public as a brilliant branch of the profession, and the temptation to a dishonest surgeon is to do things that will make a brilliant show instead of things most to the interest of the patient.

"My favorite operation is litholapaxy—special bladder operation. In the general pain of sickness women tolerate pains better than men, unless special circumstances arise to disturb them, when they become more readily excited and less amenable to reason than men."—Chicago Tribune.

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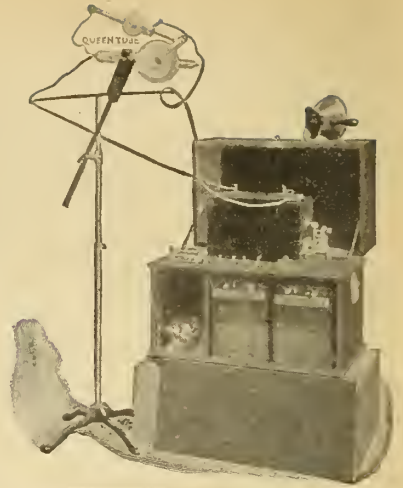
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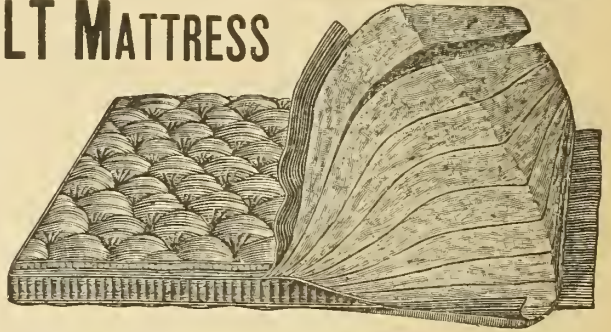


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